HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Sex: _____________________________ Person completing this form: ____________________________________________

Why are you here to see the doctor? _________________________________________________________________________
__________________________________________________________________________________________________

Does the child have any allergies (including environmental, medication, food, reaction to previous blood transfusion)?
YES  NO If YES - Please list: ___________________________________________________________________________
__________________________________________________________________________________________________

Is the child currently taking any medications or drugs (including over-the-counter, prescription, health store medications, birth control pills)?
YES  NO If YES - Please list: ___________________________________________________________________________
__________________________________________________________________________________________________

Does the child have any chronic conditions or any previous serious illnesses? YES  NO If YES - Please list: _____________________
__________________________________________________________________________________________________

SURGICAL/HOSPITALIZATION HISTORY: NO  YES

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery Performed and/or Reason for Hospitalization</th>
<th>General Anesthesia or Sedation Given?</th>
<th>List any problems with General Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>YES  NO</td>
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<td>YES  NO</td>
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<td></td>
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<td>YES  NO</td>
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</tbody>
</table>

PATIENT SUBSTANCE USE:

Tobacco:  Never  Quit  Passive  YES / Alcohol:  NO  YES _________ oz/wk / Drugs:  NO  YES ______________ use/wk

BIRTH HISTORY:

Full Term  Premature (Weeks ___)  Vaginal  Caesarean  Healthy at Birth  Birth Length: _________  Birth Weight: _______
If hospitalized, Where? ____________________________________________  Birth/Pregnancy Problems (if any): _______________________

Please return completed form to the medical assistant or nurse.
HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Patient’s Name: _________________________________________

FAMILY HISTORY: Please indicate the child’s family history. For Aunt, Uncle and Grandparents note M for Maternal and P for Paternal

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Sister</th>
<th>Aunt</th>
<th>Uncle</th>
<th>Grandmother</th>
<th>Grandfather</th>
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<tbody>
<tr>
<td>DVT/pulmonary embolism</td>
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<td>Kidney Disease</td>
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<td>Heart Disease</td>
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<td>Stroke</td>
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<td>Congenital Hearing Loss</td>
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<td>Sickle Cell Anemia</td>
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<td>Anesthesia Problems</td>
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<td>OTHER</td>
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</tbody>
</table>

SOCIAL HISTORY:

Are there any smokers in the patient’s home?  ○YES  ○NO If YES - Who? _______________________________________________

Child lives with (check applicable) ○Mom ○Dad ○Grandparent ○Brother (#): ___ ○Sister (#): ___ ○Foster Parent ○Legal Guardianship/Custody: ____________________________________________

Mother’s Age: ______ Mother’s level of education: ○High school diploma/GED ○Some College ○College Graduate

Father’s Age: ______ Father’s level of education: ○High school diploma/GED ○Some College ○College Graduate

List all sibling(s) Name: __________________ Age: _____ Same Parents ○YES ○NO /
Name: __________________ Age: _____ Same Parents ○YES ○NO
Name: __________________ Age: _____ Same Parents ○YES ○NO
Name: __________________ Age: _____ Same Parents ○YES ○NO
Name: __________________ Age: _____ Same Parents ○YES ○NO
Name: __________________ Age: _____ Same Parents ○YES ○NO
Name: __________________ Age: _____ Same Parents ○YES ○NO
Pets: _______________ ○Other: __________________

Is the patient enrolled in CMS?  ○YES ○NO Other Agencies involved with this patient?  ○YES ○NO Agency Name: __________________

Do you have transportation needs?  ○YES ○NO If YES - Please explain: _______________________________________________

Please return completed form to the medical assistant or nurse.
**HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:**

**Review of Systems:** Please indicate whether the following are problems for your child. (Check all that may apply)

### Newborn:
- Healthy at Birth
- Apnea
- Retinopathy
- Bradycardia
- Intraventricular Hemorrhage/Head Bleed
- Incubation/ Mechanical Ventilation
- BPD (Bromchopulmonary Dysplasia)
- Other/Details:

### Constitutional/General:
- Normal
- Frequent Infection
- Fever
- Weight Loss
- Fatigue
- Unusual Sweating
- Other/Details:

### Respiratory:
- Normal
- Asthma
- Shortness of Breath
- Chest Pain
- TB
- Aspiration
- Croup
- Pneumonia
- Chronic Cough
- Tracheostomy/Intubation/Mechanical
- Other/Details:

### Cardiac:
- Normal
- Congenital Heart Defects
- Racing Heart
- Cardiotoxic Drugs
- Blood Pressure Problems
- Murmurs
- Arrhythmias (Irregular Heartbeat)
- Other/Details:

### Genitourinary:
- Normal
- Kidney Disease
- UTI (Urinary Tract Infection)
- Vesicoureteral Reflex
- Vaginal Bleeding
- Excessive Urination
- Stones
- Ovary Problems
- Undescended Testicle
- Excessive Menstruation
- Incontinence
- Pelvic Pain
- Blood in Urine
- Testicular Mass/Pain
- Other/Details:

### Hepatic:
- Normal
- Liver Disease
- Jaundice (Yellow Skin)
- Gall Stones
- Hepatitis
- Pancreatitis
- Other/Details:

### Neurologic:
- Normal
- Seizures
- Migraines
- Stroke
- Change in School Performance
- Weakness
- Dizziness
- Headache
- Walking Problems
- Hydrocephalus/Shunt
- Meningitis
- Balance Problems
- Other/Details:

### Gastrointestinal:
- Normal
- Diarrhea
- Vomiting/Nausea
- Abdominal Pain/Swelling
- Constipation
- GE Reflex
- Blood in Stool
- Hepatitis
- Colitis
- Vomiting Blood
- Other/Details:

(Review of Systems continued on next page)
## HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Patient’s Name: _________________________________________

### REVIEW OF SYSTEMS: Please indicate whether the following are problems for your child. (CHECK ALL THAT MAY APPLY)

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL:</th>
<th>SKIN:</th>
<th>ENDOCRINE/METABOLIC:</th>
<th>PSYCHOSOCIAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Muscle Disease</td>
<td>Rash</td>
<td>Diabetes</td>
<td>Developmental Delay</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Easy Bruising</td>
<td>Thyroid Disorders</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>Birthmarks</td>
<td>Inborn Errors of Metabolism</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>Scars</td>
<td>Adrenal Disorders</td>
<td>ADD/ADHD</td>
</tr>
<tr>
<td>Fractures</td>
<td>Pallor</td>
<td>Other/Details:</td>
<td>Autism</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Hemangioma</td>
<td>Other/Details:</td>
<td>Depression</td>
</tr>
<tr>
<td>Joint Pain</td>
<td>Burns</td>
<td></td>
<td>Other/Details:</td>
</tr>
<tr>
<td>Bone Pain/Mass</td>
<td>Other/Details:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEMATOLOGIC:

- Normal
- Bleeding Disorder
- Prior Transfusion
- Pallor
- Anemia
- Leukemia
- Blood Clot
- Easy Bleeding/Brusing
- Lymphoma
- Other/Details:

### REVIEW OF SYSTEMS:

#### MUSCULOSKELETAL:
- Normal
- Muscle Disease
- Arthritis
- Muscular Dystrophy
- Scoliosis
- Fractures
- Back Pain
- Joint Pain
- Bone Pain/Mass
- Other/Details:

#### SKIN:
- Normal
- Rash
- Eczema
- Easy Bruising
- Birthmarks
- Scars
- Pallor
- Hemangioma
- Burns
- Other/Details:

#### ENDOCRINE/METABOLIC:
- Normal
- Diabetes
- Thyroid Disorders
- Inborn Errors of Metabolism
- Adrenal Disorders
- Other/Details:

#### PSYCHOSOCIAL:
- Normal
- Developmental Delay
- Learning Disability
- Substance Abuse
- ADD/ADHD
- Autism
- Depression
- Other/Details:

### DEVELOPMENTAL HISTORY: Answer all questions that apply to your child’s age.

Is your child toilet trained? **YES** **NO** If **YES** do you have concerns regarding toilet training? ______________________________________________________________________

For **Infants/Toddlers**:
- Does your child: Roll over? **YES** **NO** Sit alone? **YES** **NO** Walk? **YES** **NO** Talk? **YES** **NO** Drink from a cup? **YES** **NO**

For **Preschool Children**:
- Attend daycare? **YES** **NO** Has there been concern over development or speech? **YES** **NO**

For **School Age Children**:
- Grade: ________ School: __________________________ School Performance: __________________________
- Other activities (work, sports, church, etc): ______________________________________________________________________
- Has your child’s intelligence or development ever been tested? **YES** **NO** If **YES**, by Whom, Where, & When? ______________________________________________________________________

Up to date on Immunizations? **YES** **NO** Which: ______________________________________________________________________

For girls: Age first menstruated? ______________________________________________________________________

Please return completed form to the medical assistant or nurse.