Cayuga MEDICAL CENTER
A Member of Cayuga Health System

Cayuga Hematology Oncology Associates

New Patient Health History Questionnaire

Name: _____ Today's Date: _____

Address: _____
City State, Zip Code

Email Address: _____

Date of Birth: _____ Home Telephone #: _____

Cell Number:_____ Work Number: _____

Emergency Contact name & number:_____

Referred by: _____

Reason for Office Visit Today: _____

Primary Care Physician

Name: _____

Phone #: _____

Address: _____
City State, Zip Code

Any Other Providers: _____

_____

_____

_____

Insurance Information

Please bring your Medicare Part "D" or any other prescription card with you so we can make a copy of it for our records.

Primary Insurance

Company Name: _____

Policy Number: _____

Policy Holder: _____

Secondary Insurance

Company Name: _____

Policy Number: _____

Policy Holder: _____

Health History

Please answer the following questions. If several choices are given, circle the appropriate choice. Where appropriate, give dates of the onset of symptoms and describe how the problem has been treated.

1. Do you fatigue easily? ☐ Yes ☐ No
   In response to what activities? _____
2. Have you gained or lost more than 10 lbs in the past 6 months? ☐ Yes ☐ No
   To what do you attribute this gain or loss? _____
3. Do you experience night sweats? ☐ Yes ☐ No
   If Yes, how frequently? _____
4. Do you experience lightheadedness, headaches, room-spinning dizziness, or fainting spells?
   Any vision problems? _____ ☐ Yes ☐ No
5. Do you ever lose your balance or sense of position? _____ ☐ Yes ☐ No
6. Do you have numbness or tingling in any of your extremities? ☐ Yes ☐ No
   _____
7. Do you have hearing loss in either or both ears? ☐ Yes ☐ No
   _____
8. Do you ever have ringing in or discharge from your ears? ☐ Yes ☐ No
   _____
9. Do you experience bloody noses? _____ ☐ Yes ☐ No
10. Do you have history of lung problems, difficulty breathing or shortness of breath? _____ ☐ Yes ☐ No
    Do you have a chronic cough? ☐ Yes ☐ No Cough up blood? ☐ Yes ☐ No
    Date of last chest X-ray? _____ At what hospital? _____
11. Do you have history of any cardiac problems, chest pain, high or low blood pressure, enlarged heart or murmur? ☐ Yes ☐ No
    _____
12. Do you have indigestion, food intolerance, nausea or vomiting, heartburn or regurgitation? ☐ Yes ☐ No
    _____
13. Are your bowel movements regular? ☐ Yes ☐ No
    Describe any recent changes in your bowel habits. Do you have bloody or tarry stools; change in character of stools, frequent diarrhea? _____
    Date/Place of last Colonoscopy _____ Any polyps? _____
    Result: _____
14. Do you have difficulty urinating? ☐ Yes ☐ No
    Any blood or pus in urine? _____
    How frequently during the day do you urinate? _____
    During the night? _____
15. Do you have swollen, stiff or painful joints? ☐ Yes ☐ No
    _____
16. Do you have pain, decreased temperatures, swelling or discoloration in your extremities? ☐ Yes ☐ No
    _____
17. Do you experience back pain? ☐ Yes ☐ No
    _____

Health History (continued)

18. Do you have difficulty falling or staying asleep? ☐ Yes ☐ No

19. Do you have nervous or mental difficulties? ☐ Yes ☐ No

20. Do you have any skin problems such as rashes, open areas, discolorations or raised areas which have changed? ☐ Yes ☐ No

21. Do you have anemia or any bleeding disorders? ☐ Yes ☐ No

22. Do you bruise easily? ☐ Yes ☐ No

23. Do you have swollen glands? ☐ Yes ☐ No
    If so, where? _____

24. Have you ever had a blood transfusion? Dates: _____ ☐ Yes ☐ No

25. Have you ever had any endocrine conditions such as diabetes or thyroid problems? ☐ Yes ☐ No

26. Please list all surgeries with dates, type, location and surgeon.

Date	Type	Location	Surgeon

Females:

1. At what age did you begin menstruating? _____
2. Do you have irregular or painful periods? _____ ☐ Yes ☐ No
3. Date of last menstrual period? _____
4. How many pregnancies? _____ Live births_____ Abortions? ____ Miscarriages? _____
5. Did you breast feed? ☐ Yes ☐ No
6. Date of last Pap smear? _____Date of last Mammogram? _____
7. Did you ever take hormones or birth control pills? ☐ Yes ☐ No
   For how long? _____

Males:

Have you experienced?

1. Erectile problems, libido increase/ decrease? _____ ☐ Yes ☐ No
2. Testicular pain, enlargement or lumps? _____ ☐ Yes ☐ No

Social History

Marital Status:
☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant other ☐ Single ☐ Widowed
☐ Other _____

I currently live: ☐ Alone ☐ With family; Name: _____
☐ With friends; Name: _____ ☐ With significant other; Name: _____
☐ Assisted living/ Nursing home Name: _____

What is your occupation? (Current or past) _____
Highest level of education: _____

Do you currently drink alcohol? ☐ Yes ☐ No
If yes, maximum consumed per week:
• Glasses of wine_____
• Cans/bottles of beer_____
• Shots of liquor_____

Did you ever drink alcohol? ☐ Yes ☐ No
If yes, maximum consumed per week:
• Glasses of wine_____
• Cans/bottles of beer_____
• Shots of liquor_____

Are you sexually active? ☐ Yes ☐ No ☐ Not currently
If yes, is/are your partner(s): ☐ Male ☐ Female ☐ Both
Type of birth control/ protection currently used:
☐ Not having sex (Abstinence) ☐ Condom ☐ Injection ☐ IUD (Intrauterine Device)
☐ Oral contraceptives (Pill) ☐ Patch ☐ Post-menopausal ☐ None ☐ Other (specify) _____
Have you ever been tested for HIV? ☐ Yes ☐ No
Most current date:_____Result? _____

Do you or did you use illicit drugs? ☐ Yes ☐ No
If you use/used drugs, what type(s) of drugs do/did you use? _____
How many times a week? _____

Check one of the following about smoking tobacco:
☐ Never smoked ☐ Former smoker ☐ Smoke some days ☐ Smoke every day
☐ Exposed to second hand smoke
If you smoke or used to smoke, how many packs do/ did you smoke per day? _____
How many years did you smoke/ have you smoked? _____
If you quit, when did you quit? _____
Do you ever use “smokeless tobacco”? (Select one below)
☐ Former user ☐ Current user ☐ Never used If you quit, when did you quit? _____

Are you ready to quit smoking/ or using smokeless tobacco? ☐ Yes ☐ No

Have you or anyone in your family have or had breast, colon, rectal, ovarian, gastric (stomach), prostate, pancreatic, uterine cancer, or melanoma? ☐ **Yes (Self)** ☐ **Yes (family member)** ☐ **No**

Are you being referred for genetic risk assessment? ☐ **Yes** ☐ **No**

If you answered yes to either of the above questions, please fill out questions 1 through 6.

Include all 1st, 2nd, 3rd, degree relatives who have cancer (including yourself)

1st degree: Parents, Brothers, Sisters, Half-siblings, Children

2nd degree: Uncles, Aunts, Nieces, Nephews, Grandparents, Grandchildren

3rd degree: Great Grandparents, Great Uncles/Aunts, First Cousins

1. Please List the Following Family Information:

Name	Relationship	Maternal / Paternal	Type of Cancer	Age at First Cancer	Current Age or Age at Death

2. For Relatives with Breast Cancer, Also Provide the Following (if known):

Number from Above	Unilateral vs. Bilateral	Invasive or Noninvasive (DCIS)	Triple Negative Yes, No, Unknown

3. **Have any of these family members been diagnosed with a second primary cancer?** ☐ Yes ☐ No ☐ Unknown
If Yes, please provide type of cancer and age: _____

4. Has anyone in your family had colon polyp(s)? ☐ Yes ☐ No ☐ Unknown
If Yes, please list age of first polyp(s) and their relationship to you: _____

5. Has anyone in your family been tested for havng genetic cancer? ☐ Yes ☐ No ☐ Unknown
If Yes, please list relationship to you and what syndrome(s): _____
Did they test? ☐ Positive ☐ Negative ☐ Indeterminate
Date they were tested: _____

6. Are any of your relatives of Ashkenazi Jewish heritage? ☐ Yes ☐ No ☐ Unknown

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Family History

Check below to report problems your family members have had. Please state the age when they had problems if you know it.

☐ I was adopted so I do not know my family history.

Do you have any family with:

Anemia	☐ Yes ☐ No	Relationship: _____
Bleeding Disorder	☐ Yes ☐ No	Relationship: _____
Clotting Disorder	☐ Yes ☐ No	Relationship: _____
Cancer	☐ Yes ☐ No	Relationship: _____
Leukemia	☐ Yes ☐ No	Relationship: _____
Lymphoma	☐ Yes ☐ No	Relationship: _____

Relative	Living	Deceased	Age	Health Problems
Father				
Mother				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Child M/F				
Child M/F				
Child M/F				
Child M/F				
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				

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Pharmacy

Name: _____

Address: _____

_____

Phone Number: _____

If you use a mail order pharmacy, which one?

_____

Please bring your Medicare Part "D" or any other prescription card with you so we can make a copy of it for our records.

Allergies	Reaction
1.	
2.	
3.	
4.	

Current Medications (Prescriptions & over the counter)

Name	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Current Supplements / Vitamins

Name	Dose	Frequency
1.		
2.		
3.		
4.		

Please write on separate paper if you need more room.

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