

HEMATOLOGY/ONCOLOGY HISTORY FORM (continued)

Drug Store: _____

Date of last immunizations (flu, pneumonia, tetanus): _____

Family History:

	Living	Deceased	Health Problems or Cause of Death
Children (List Separately):	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brothers and/or Sisters (List Separately):	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any other family members have cancer or a blood disorder? If so, who and what: _____

Social History:

M S W D # Children: _____

Primary Care Giver (contact person): _____ Home phone #: _____

Phone # other than home: _____

Patient's Occupation: _____

Are you presently working: Yes No Full-time Part-time

Do you feel safe from physical and emotional abuse in your life: Yes No

Do you smoke or have you ever smoked? Yes No # Packs/day _____ How long? _____

When stopped? _____

Do you drink alcohol? Yes No Amount _____ Do you use unprescribed drugs? Yes No

Physical limitations: _____

Agencies currently involved in Home Care (home oxygen): _____

Communication:

No limitations Visual impairment Learning/reading difficulty

Hearing loss Retardation Other: _____

Speech difficulty

Education:

Highest grade completed: _____

Religious Preference: _____

Do your beliefs prohibit receiving blood/blood products? Yes No

Previous blood transfusion? Yes No Previous reaction? Yes No

Do you have a North Carolina Living Will or Healthcare Power of Attorney? Yes No

If NO, would you like information on either? Yes No Information given? Yes No

Are you an Organ Donor? Yes No Information given? Yes No

Physician Signature / Date

Patient Signature / Date