



**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

**Patient Signature:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_