

**PENNSYLVANIA ONCOLOGY HEMATOLOGY ASSOCIATES
PATIENT QUESTIONNAIRE**

Name: _____ **Age:** _____ **Date:** _____

REASON FOR VISIT:

SERIOUS CHILDHOOD ILLNESSES:

OPERATIONS:	SURGEON:	YEAR:	HOSPITAL:
--------------------	-----------------	--------------	------------------

1.

2.

3.

4.

5.

Any Transfusions: Yes/No How Many? _____ When? _____

HOSPITALIZATIONS:	DATE:	PLACE:
--------------------------	--------------	---------------

1.

2.

3.

4.

PENNSYLVANIA ONCOLOGY HEMATOLOGY ASSOCIATES
PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

ILLNESSES AS AN ADULT:

DATE:

- 1.
- 2.
- 3.
- 4.
- 5.

STRESS (WORK, FAMILY, ETC):

PRESENT MEDICATIONS: (List all including Vitamins and Aspirin)

Name or Type:

Began?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

ALLERGIES TO MEDICINES:

LIST EFFECTS:

- 1.
- 2.
- 3.
- 4.
- 5.

MENSES: BEGAN AT AGE:

LMP:

MENOPAUSE:

**PENNSYLVANIA ONCOLOGY HEMATOLOGY ASSOCIATES
PATIENT QUESTIONNAIRE**

Name: _____ Age: _____ Date: _____

OCCUPATION:

PRESENT:

PREVIOUS:

- 1.
- 2.
- 3.

SINGLE: _____ **MARRIED:** _____ **DIVORCED:** _____

WIDOWED: _____ **SEPERATED:** _____

CHILDREN: **BOYS:** _____ **GIRLS:** _____

Children's Health Problems:

Habits	No	Yes	When Started	When Stopped	Amount
Smoking					Packs per day: _____
Alcohol					Liquor/Day ____ Beer/Day ____ Wine/Day ____
Coffee					Cups/Day ____
Other Drugs					