Weill Cornell Medical College of Cornel University
Department of Medicine – Division of Hematology and Medical Oncology

PATIENT SELF-ASSESSMENT FORM

Please complete the information below to the best of your ability.

Personal Information

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Telephone: _____ Email: _____

Name of referring physician:_____

Address:_____

City:_____State:_____Zip:_____

Telephone:_____ Fax:_____

Name of primary care physician:_____

Address:_____

City:_____State:_____Zip:_____

Telephone:_____ Fax:_____

Please list any additional physicians you would like reports from today's visit to be sent to:

Physician's Name	Address	Telephone
1.		
2.		
3.		

Reason for your visit:_____

Allergies

☐ I have no known drug allergies

Please list medications that you are allergic to, if any:

1._____ Reaction:_____

2._____ Reaction:_____

3._____ Reaction:_____

Medical History

Have you been or are you currently being treated for the following conditions?

Cancer ☐ Yes ☐ No

If yes, specify type(s) of cancer(s) and date(s) of diagnosis: _____

_____

Other blood problem ☐ Yes ☐ No

If yes, specify type(s) of problem (s) and date(s) of diagnosis: _____

_____

Heart attack	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Peripheral vascular disease	☐ Yes	☐ No
Dementia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Pulmonary disease/COPD	☐ Yes	☐ No
Autoimmune condition	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Peptic ulcer disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Viral hepatitis	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Kidney failure	☐ Yes	☐ No
Psychiatric problems	☐ Yes	☐ No

Hereditary conditions	☐ Yes	☐ No
Blood clots in your legs	☐ Yes	☐ No
Blood clots in your lungs	☐ Yes	☐ No

Surgical History

Have you ever undergone any surgical procedure(s): ☐ Yes ☐ No

If "yes", please specify including dates:

_____

_____

_____

Family History

Please list any medical conditions for the following family members (if there is a history of cancer, please be as specific as possible):

Father _____ Alive? ☐ Yes ☐ No

Mother _____ Alive? ☐ Yes ☐ No

Grandmother _____ Alive? ☐ Yes ☐ No

Grandfather _____ Alive? ☐ Yes ☐ No

Son _____ Alive? ☐ Yes ☐ No

Daughter _____ Alive? ☐ Yes ☐ No

Brother _____ Alive? ☐ Yes ☐ No

Sister _____ Alive? ☐ Yes ☐ No

Please list any other pertinent family medical history:

_____

_____

_____

Race

Do you consider yourself (check all that apply):

- ☐ White
- ☐ Black
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaska Native

Ethnicity

Do you consider yourself of Hispanic or Latino or Spanish origin: ☐ yes ☐ no

Social History

Use of tobacco ☐ Yes ☐ Never ☐ Quit ☐ Passive

If "yes" or "quit", how many packs per day?_____

For how many years?_____

Quit date: _____

Type of tobacco ☐ cigarettes ☐ cigars ☐ pipe ☐ chew ☐ snuff

Use of alcohol: ☐ Yes ☐ No

If "yes", please specify amount consumed per week: _____

Use of recreational drugs: ☐ Yes ☐ No

If "yes", please specify:_____

Socioeconomic History

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse name: _____

Years of education: _____

Please list medications that you are currently taking, including anything over the counter:

Name of medication Dose Directions

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

Please provide your pharmacy's information:

Pharmacy name:_____

Address:_____

Telephone:_____ Fax:_____

Review of Systems:

Please indicate if you currently experience any of the following signs and/or symptoms:

Constitutional	**Yes**	**No**
Weight change	☐	☐
Change in appetite	☐	☐
Fever	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐
Generalized weakness	☐	☐
Pain	☐	☐

Eyes	**Yes**	**No**
Wear glasses/contacts	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐
Floaters	☐	☐
Burning/itching/watery	☐	☐
Pain/redness/dryness	☐	☐

Ear/Nose/Throat	**Yes**	**No**
Tinnitus/ringing	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Recurrent ear infection	☐	☐
Nasal congestion	☐	☐
Sinus problem	☐	☐
Post-nasal drip	☐	☐
Discharge	☐	☐
Epistaxis/nose bleeds	☐	☐
Dental problem	☐	☐
Mouth sores	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐
Neck swelling	☐	☐

Cardiovascular	**Yes**	**No**
Chest pain	☐	☐
Palpitation	☐	☐
Shortness of breath at night	☐	☐
Difficulty breathing lying flat	☐	☐
Swelling of feet/ankles/hands	☐	☐
Pain in legs while walking	☐	☐
Fainting spells	☐	☐
Fast or slow heartbeat	☐	☐

Respiratory	**Yes**	**No**
Shortness of breath	☐	☐
Wheezing	☐	☐
Chronic/frequent coughs	☐	☐
Coughing up blood	☐	☐
Coughing up sputum	☐	☐
Noisy breathing/snoring	☐	☐

Gastrointestinal	**Yes**	**No**
Trouble swallowing	☐	☐
Heartburn	☐	☐
Reflux	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting blood	☐	☐
Change in bowel movements	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stools	☐	☐
Dark black stools	☐	☐
Bloating/gas	☐	☐
Abdominal pain	☐	☐
Jaundice	☐	☐

Musculoskeletal	**Yes**	**No**
Bone pain	☐	☐
Stiffness	☐	☐
Backache	☐	☐
Muscular weakness	☐	☐
Difficulty/pain in walking	☐	☐
Fractures	☐	☐
Muscle pain/cramps	☐	☐
Joint pain	☐	☐
Joint swelling	☐	☐

Genitourinary	**Yes**	**No**
Frequent urination	☐	☐
Urinating at night	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Urgent urination	☐	☐
Incontinence	☐	☐
Dribbling	☐	☐
Reduced force of stream	☐	☐
Hesitancy	☐	☐
Infections	☐	☐

Integumentary	**Yes**	**No**
Rash	☐	☐
Itching	☐	☐
Sores	☐	☐
Ulcers	☐	☐
Changes in skin color	☐	☐
Changes in hair or nails	☐	☐
Varicose veins	☐	☐

Neurological	**Yes**	**No**
Fainting	☐	☐
Blackouts	☐	☐
Convulsions/seizures	☐	☐
Weakness	☐	☐
Paralysis	☐	☐
Numbness/loss of sensation	☐	☐
Tingling/pins and needles	☐	☐
Tremors	☐	☐
Headaches	☐	☐
Lightheaded/dizzy/vertigo	☐	☐
Memory loss	☐	☐

Endocrine	**Yes**	**No**
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Excessive thirst	☐	☐
Excessive urination	☐	☐
Excessive hunger	☐	☐
Excessive urination	☐	☐
Excessive sweating	☐	☐
Glandular or hormone issues	☐	☐

Hematologic/Lymphatic	**Yes**	**No**
Easy bleeding	☐	☐
Easy bruising	☐	☐
Slow to heal after cuts	☐	☐
Low blood counts	☐	☐
Lump on breast/neck	☐	☐

Allergic/Immunologic:	**Yes**	**No**
Recurrent skin infections	☐	☐
Anaphylaxis	☐	☐
Lip swelling	☐	☐
Skin tightness	☐	☐
Hair loss	☐	☐
Morning stiffness	☐	☐
Raynaud's	☐	☐
Skin reactions or adverse reaction to:		
Drug/medication	☐	☐
Anesthesia	☐	☐
Food	☐	☐

Psychiatric:	**Yes**	**No**
Nervousness	☐	☐
Anxiety/panic attack	☐	☐
Tension	☐	☐
Memory loss/confusion	☐	☐
Sleep problems	☐	☐
Depressed mood	☐	☐
Hallucination	☐	☐

Male:	**Yes**	**No**
Testicle pain/lumps	☐	☐
Prostate problems	☐	☐
Reduced libido/desire	☐	☐

Female:	**Yes**	**No**
Irregular periods	☐	☐
Vaginal yeast infections	☐	☐
Reduced libido/desire	☐	☐
Pregnant or nursing	☐	☐
Planning a pregnancy	☐	☐

Current form of birth control:_____

Last menstrual cycle:_____

Age at onset of menstruation:_____

Age at onset of menopause:_____

_____

Patient's signature Date

I have reviewed all information with the patient _____

Physician's signature Date