Hematology Clinic

New Patient Information Form

Welcome to the Duke Hematology Clinic. In order that we can spend most of our time on the issues that matter the most to you, please complete this new patient questionnaire as completely as possible. The last two pages are an authorization for release of any medical records that may be relevant to our evaluation. Please also complete that form and bring it with you to the clinic. Thank you!

Duke History Number:

Personal Information

Date: ____/____/____

Name: ______________________________________ (Please circle: Miss/Ms./Mrs/Mr./Dr./Rev.)

Spouse's Name/Significant Other: ____

Address: ______________________________ City: ______________ State: ____ Zip: ________

Home Telephone: (____) _____________Mobile Telephone: (____) ___________

Work Telephone: (____) _____________

Email Address: ____

Next of kin or close friend (NON-spouse) who generally would know your whereabouts:

Name: ______________________________________ (Please circle: Miss/Ms./Mrs/Mr./Dr./Rev.)

Address: ______________________________ City: ______________ State: ____ Zip: ________

Home Telephone: (____) _____________Mobile Telephone: (____) ___________

Work Telephone: (____) _____________

Why are you being referred to the Hematology Clinic?

____

____

____

Past Medical History:
Illnesses or chronic medical problems and year first diagnosed:

High Blood Pressure	_______	Hepatitis	_______	Lupus/Scleroderma	_______
Heart Attack	_______	Jaundice	_______	Multiple Sclerosis	_______
Heart Failure	_______	Gall Bladder Disease	_______	Arthritis	_______
Rheumatic Heart Disease	_______	Ulcerative Colitis	_______	Glaucoma	_______
Emphysema/Bronchitis	_______	Crohn's Disease	_______	Stroke	_______
Asthma	_______	Kidney Disease	_______	Seizures/Convulsions	_______
Pneumonia	_______	Kidney Stone	_______	Migraine Headaches	_______
Tuberculosis	_______	Urinary Infection	_______	Depression	_______
Peptic Ulcer Disease	_______	Thyroid Disease	_______	Anemia	_______
Cirrhosis of the Liver	_______	Diabetes/Sugar	_______	Other blood abnormality	_______

Past Operations:

Type Date Hospital

____
____
____
____
____
____
____
____

Past Injuries and Trauma:

Type Date Hospital

____
____
____

Past Transfusions:

Type Date Hospital

____
____
____

Medications:
Please list all medications, non-prescription drugs, vitamins and health supplements:

Drug Name Dose How Often For What

____
____
____
____
____
____
____
____

Allergies to Medications:

Drug Name What happens when you take it?

____

____

____

Family History:

Relation	*Age(s)*	*Medical Problems*	*If deceased, age and cause of death*
Father			
Mother			
Brother(s):#			
Sister(s):#			
Children:#			

Other blood relatives with bleeding or clotting problems: ____

____

____

Other disorders that run in your family: ____

____

Social History:

Occupation (If retired, former occupation): ____

Marital Status: ☐Single ☐Widowed ☐Married ☐Divorced

Living Situation: ☐Live alone ☐Live with ______________ ☐Family/friend/support nearby

Tobacco/Alcohol/Recreational Drug Use: ☐None or:

Type How much per day or week? How many years? If you quit, when?

____

____

____

____

Education: (Circle Highest)	1 2 3 4 5 6 7 8 Elementary/Middle	1 2 3 4 High School	1 2 3 4 over 4 College

Review of Systems:

Nutritional Status:

Height ______ feet ______ inches Current Weight: ________ pounds

Weight, two weeks ago: _________ pounds Weight, 6 months ago: ________ pounds

Diet:

☐ Regular diet

☐ Restricted diet (Restriction: ____)

☐ Little solid food

☐ Only nutritional supplements (List: ____)

☐ Only liquid nourishment by feeding tube

Functional Capacity:

☐ Normal, no limitations

☐ Not your normal self, but able to be up and about with fairly normal activities

☐ Not feeling up to most things, but in bed less than half the day

☐ Able to do little activity and spend most of day in bed

☐ Pretty much bedridden, rarely out of bed

Please circle any of the symptoms listed below that you have had during the last two months:

General

Fever
Chills
Night sweats
Marked fatigue or weakness
Loss of Appetite
Weight loss
Weight gain

HEENT

Headache/Migraines
Double vision
Loss of vision
Blurry vision
Hearing loss
Sinusitis or postnasal drip
Sore throat
Change in voice
Dry mouth or eyes
Sores in nose, mouth or lips
Enlarged lymph glands
Bleeding gums
Nosebleeds

Pulmonary

Shortness of breath
Cough
Sputum or phlegm
Coughing up blood
Wheezing
Bronchitis
Pneumonia

Cardiovascular

Chest pain
Angina
Short of breath with exertion
Awaken short of breath
Heart murmur
Hearth fluttering
Dizziness, lightheaded
Short of breath lying flat
Swelling of both legs
Pain in calf with exercise
Varicose veins

Gastrointestinal

Nausea
Vomiting
Vomiting blood
Vomiting “coffee grounds”
Pain with swallowing
Heartburn
Peptic ulcer
Colitis
Diarrhea
Bloody stools
Black tarry stools
Hemorrhoids
Constipation
Change in bowel habits
Abdominal pain
Jaundice

Genitourinary

Pain or burning with urination
Blood in urine
Increased frequency of urination
Urination at night
Decrease in size or force of stream
Incontinence
Kidney stones
Impotence or difficulty with sex
Sores or lumps in genitals (privates)

Neurological

Loss of balance
Numbness or tingling
Localized weakness
Tremors
Blackout spells
Seizures
Dizziness, room spinning
Stroke/Ministroke

Musculoskeletal

Arthritis
Joint stiffness
Joint swelling
Gout
Muscle weakness

Endocrine

Heat/Cold intolerance
Diabetes
Excessive sweating
Thyroid disease
Increased water drinking

Dermatology

Nail changes
Hair loss
Skin rash
Sores
Itching
Moles

Psychiatric

Depression
Anxiety
Tension
Insomnia

Hemostasis: Please circle if you have ever had any of the symptoms listed below:

Tooth extractions
Bleeding after tooth extractions
Nosebleeds
Blood clot in lung
Blood clot in leg
Phlebitis
Easy bruising
Free bleeder
Prolonged bleeding
Bruises larger than 6 inches
Lumps with bruises
Bleeding after surgery
Blood transfusions
Abnormal clotting time
Anemia
Low platelet count
Taken aspirin
Take Motrin
Taken Coumadin (warfarin)
Taken Heparin
Taken Plavix
Had cancer

Reproductive history (for females):

Your age when period began: ______ Date of last period: _______________

Days bleeding/cycle: _______________ Maximum pads/tampons per day: ___________

Total pregnancies: __________ Age of first childbirth: ___________

How many children born alive: __________ How many miscarriages or abortions: ________

Excessive bleeding following childbirth: ☐Yes ☐No

Are you or could you be pregnant: ☐Yes ☐No

Do you have a history of benign breast problems: ☐Yes ☐No

Previous breast biopsies: ☐Yes ☐No

Date of last PAP smear: _____________________

Date of last mammogram: ____________________

Problems associated with pregnancy or with any other gynecological illnesses: ☐Yes ☐No

Kind Date(s)

____

____

____

Health screening:

Have you had:			
	PSA (men only)	☐Yes	☐No
	Colonoscopy	☐Yes	☐No
	Stool for blood	☐Yes	☐No
	Cholesterol	☐Yes	☐No

Living Will and Health Care Power of Attorney:

The Patient Self-Determination Act of 1990 requires all health care providers to inform you of the right to accept or refuse medical treatment. More information on your options regarding your treatment decision, preparing a living will, or assigning a Health Care Power of Attorney is available. If you would like further information on this, please ask a member of the staff.

Do you currently have a living will or health care power of attorney? ☐Yes ☐No

Would you like more information about this? ☐Yes ☐No

Insurance:

Do you have health insurance: ☐Yes ☐No

Does it pay for prescriptions: ☐Yes ☐No

What is your prescription co-pay: $________________

Social work needs:

Do you need to see a social worker regarding any of the following (check all that apply):

☐Lodging

☐Equipment needs (home oxygen, hospital bed, walker, etc…)

☐Transportation

☐Medications

☐Insurance or disability

Are you currently receiving home health care? ☐Yes ☐No

If yes, name of agency: ____

The information recorded in this form has been reviewed with the patient.

Patient Signature: ____

Physician Signature: ____

REFERRING PHYSCIAN INFORMATION AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Page 1 of 2)

Patient Name: ____

Duke History Number: ______________________ **Date of Birth**: ____________________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individuals or organizations are authorized to make the disclosure:

What doctor sent you here today?
Name: ______________________________
Address: ____________________________ City: __________ State: ____ Zip: ________
Office telephone: (   )________________ FAX: ( )__________________

Family doctor or primary care physician:
Name: ______________________________
Address: ____________________________ City: __________ State: ____ Zip: ________
Office telephone: (   )________________ FAX: ( )__________________

Other doctors that you see:
Name: ______________________________
Address: ____________________________ City: __________ State: ____ Zip: ________
Office telephone: (   )________________ FAX: ( )__________________

Hospitals you have been admitted to other than Duke Hospital:

Hospital name	City	State	Hospitalization dates

3. I hereby authorize and request release of ALL medical information in your possession concerning my illness and/or treatment.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

5. This information may be disclosed to and used by **Dr. ____________________________, Division of Hematology, DUMC-_______________, Duke University Medical Center, Durham, NC 27710, FAX (919) 681-6160** for the purpose of ongoing medical care.

REFERRING PHYSICIAN INFORMATION AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Page 2 of 2)

6. **I understand I have the right to revoke this authorization at any time.** I understand if I revoke this authorization I must do so in writing and present my written revocation to **Dr. ______________** or his/her staff. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in 12 months.

7. **I understand that authorizing disclosure of this health information is voluntary**. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand I may inspect or copy this information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **Dr. _______________** at the address listed above or by telephone at (919) 684-5350.

____ __________________________

Signature of Patient or Legal Representative Date

____ ______________________

If signed by Legal Representative, Relationship to Patient Signature of Witness