Personalized Hematology – Oncology OF WAKE FOREST

Tell Us How You Feel Today!

Patient Name: _____ Date _____

What do you most want to discuss today? _____
(This is to help us with your concerns for THIS VISIT)

Please circle and explain yes answers.

General		**Cardiovascular**		**Musculoskeletal**		**Neurological**	
Fatigue	Yes	Chest Pain	Yes	Joint Pain (Specify which)	Yes	Numbness/Tingling	Yes
Decreased Appetite	Yes	Fainting Spells	Yes	Stiffness	Yes	Difficulty Walking	Yes
Fevers	Yes	Short of Breath Lying Flat	Yes	Muscle Weakness	Yes	Dizzy/Fainting	Yes
Weight Loss	Yes	Waking in Middle of Night	Yes	Cramps	Yes	Seizures	Yes
Weight Gain	Yes	Swelling in Extremities	Yes	Back Pain	Yes	Headaches	Yes
Insomnia	Yes						
Weak Feeling	Yes	**Gastrointestinal**		**Psychiatric**			
Chills	Yes	Nausea	Yes	Depression	Yes		
Sweats	Yes	Vomiting	Yes	Anxiety	Yes		
Do you have a living will?	Yes	Constipation	Yes	Nervousness	Yes		
Do you smoke?	Yes	Diarrhea	Yes	Changes in Mood	Yes		
Do you drink?	Yes	Abdominal Pain	Yes				
Pain Level (0-10)	____	Heartburn	Yes	**Endocrine**			
		Changes in BM	Yes	Dry Mouth	Yes		
Eyes, Ears, Nose and Throat		Difficulty Swallowing	Yes	Temp Intolerance	Yes		
Hair Loss	Yes	Bloody Stool	Yes	Excessive Thirst	Yes		
Masses	Yes	Vomiting Blood	Yes	Frequent Urination	Yes		
Visual Changes	Yes			Increased Appetite	Yes		
Double Vision	Yes	**Hem/Lymph**		Thyroid Issues	Yes		
Hearing Changes	Yes	Blood Clots	Yes				
Ear Pain	Yes	Nose Bleeds	Yes	**Respiratory**			
Runny Nose	Yes	Night Sweats	Yes	Cough	Yes		
Nasal Congestion	Yes	Bruising Easy	Yes	Short Breath	Yes		
				Mucus	Yes		
Skin/Breast		**GU/GYN and Urinary**		Wheezing	Yes		
Rashes	Yes	Incontinence	Yes	Pain	Yes		
Sores	Yes	Painful Urination	Yes	Allergies	Yes		
Changes in Moles	Yes	Blood in Urine	Yes	Hoarseness	Yes		
Nipple Discharge	Yes	Change in Urine Frequency	Yes	Palpitations	Yes		
Pain	Yes	Vaginal Discharge	Yes				
Masses	Yes	Abnormal Bleeding	Yes				
		Painful Sex	Yes				

Explanations to YES answers above: _____

_____

_____

Changes in medications since your last visit: _____

_____

_____

Name of Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Please list changes since your last visit for the following:

Any New Medical Diagnosis: _____

_____

Any New Surgeries: _____

_____

Any Changes in your Family Diagnosis: _____

_____

Any Changes in your Diet, Exercise, Occupation, and Habits: _____

_____