HUNTSMAN CANCER INSTITUTE UNIVERSITY OF UTAH

Blood and Marrow Transplant Patient Medical History

UNIVERSITY OF UTAH HEALTH CARE

Please answer these medical and personal history questions as completely as possible. Accurate medical history information is essential to a successful transplant.

Patient Name _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____

(Please include the area code with all phone numbers and indicate best number to reach you.)

Age _____ Date of Birth _____ Marital Status _____

Primary Caregiver _____ Phone _____

Race/Ethnicity (mark all that apply):

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian
_____ Hispanic
_____ Non-Hispanic
_____ White

Doctors you have seen

Referring physician _____ Phone _____

Other physician(s) you have seen about this diagnosis:

Physician _____ Phone _____

Physician _____ Phone _____

Physician _____ Phone _____

Medical History

Please list all illnesses or conditions for which you take medicine or have been hospitalized.

Illness or Condition	Diagnosis Date

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Surgical History

Please list all surgical procedures, including line placements, tumor biopsies, bone marrow biopsies, and tooth extractions. Start with most recent and work back in time.

Surgical Procedure	Procedure Date

Medications

Please list medications that you currently take. Include the date started if possible.

Medication	Start Date

Medication Allergies

List any medication you are allergic to and your reaction to it. If none, please write N/A.

Medication	Reaction

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Transfusion History

List blood products you have received such as red blood cells, platelets, intravenous immunoglobulin (IVIG), or plasma. Include reactions to blood products and if you have received medications such as Tylenol, Benadryl, or hydrocortisone before transfusions.

Blood Product	Reaction	Pretransfusion Medication?

Travel History

List all travel outside the United States, including developing nations. Also list any illnesses you contracted during foreign travel.

Foreign Destination	Date	Illness?

Childhood Illness and Vaccination History

List whether you have had or been immunized for the diseases listed below, along with the year.

Disease(s)	Vaccine or Illness?	Date
Measles, mumps, rubella		
Diptheria, tetanus, pertussis		
Polio		
Hepatitis B		
Influenza		
Chickenpox		

Have you ever had rheumatic fever?
Yes _____ No _____

If yes, what year? _____

Have you ever had cold sores?
Yes _____ No _____

Have you ever had shingles?
Yes _____ No _____

Have you ever had genital herpes?
Yes _____ No _____

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Family Medical History

For each blood relative, please list illnesses they have or had such as diabetes, heart disease, cancer, or stroke. For cancers, please list the type if you know it. If the relative has died, list the cause of death and the age at death.

Your Parents

Mother_____ Father _____

Your Siblings (if more than five, continue list on back)

Gender	Age	Illnesses
M F		
M F		
M F		
M F		
M F		

Your Mother's Side of the Family

Grandmother _____ Grandfather _____

Aunts and Uncles _____

_____

Your Father's Side of Family

Grandmother _____ Grandfather _____

Aunts and Uncles _____

_____

Your Biological Children (if more than five, continue list on back)

Gender	Age	Illnesses
M F		
M F		
M F		
M F		
M F		

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Social History

Marital status

Married (how long?) _____

Name of spouse or partner _____

Divorced ___ Number of previous marriages _____

Separated ___ Cohabiting ___ Single ___

Work status

Occupation _____

Currently working? Yes No Hours/week _____

On disability? Yes No Date started _____

Spouse's occupation _____

Education

Patient's years in school _____

Spouse's years in school _____

Residence

Own home _____ Rent _____

Single family _____ Multiple family _____

Interests

Religious preference _____

Hobbies _____

Lifestyle Choices

Tobacco

Have you ever used tobacco products? Yes No

Please mark tobacco products you have used.

Cigarettes ___ Pipe ___ Cigars ___ Chew ___ Snuff ___

How many cigarettes/pipes/cigars/chews/snuff do you use each day? _____

How long have you used tobacco? If you quit tobacco, how long did you use it? _____

If you quit,when did you stop? _____

Alcohol

Do you drink alcohol? Yes No

If yes, mark all that you use.

Beer ___ Wine ___ Hard liquor ___

How often do you use alcohol? Circle your response.

3 drinks/week or less 1 drink/day 2 drinks/day

3 drinks/day More than 6 drinks/day

Current Functional Status

Please mark the item below that best describes your current abilities.

- ❑ Normal activity with no symptoms or signs of active disease
- ❑ Normal activity with minor signs or symptoms of disease
- ❑ Normal activity with effort
- ❑ Able to care for self, but not able to do active work
- ❑ Need occasional assistance
- ❑ Need a lot of assistance and frequent medical care
- ❑ Disabled, need special care and assistance

Drugs

Have you ever used intravenous narcotics or drugs other than as prescribed by a doctor? Yes No

Are you currently using? Yes No

If yes, please state which drugs. _____

_____

If you are no longer using, when did you stop?

_____

Other Lifestyle Choices

How many different sexual partners have you had? _____

If you have or had multiple sexual partners, did/do you use condoms every time? Yes No

Have you ever had sexual relations with a member of the same sex? Yes No

Do you wear a seatbelt every time you are in a car? Yes No

Do you do extreme sports such as skydiving, paragliding, or freestyle skiing? Yes No

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Review of Symptoms

Please mark all of the symptoms you have had in the past six months.

General

- ❑ Fatigue
- ❑ Night sweats
- ❑ Fevers
- ❑ Chills
- ❑ Cold or flu symptoms
- ❑ Weight loss
  How much over what time _____
- ❑ Weight gain
  How much over what time _____

Head, Ears, Nose, and Throat

- ❑ Eye pain requiring visit to doctor
- ❑ Glaucoma
- ❑ Blurry vision
- ❑ Change in vision
- ❑ Corrective lenses
  If yes, are you nearsighted, farsighted, or both?
  _____
- ❑ Hearing loss
  If yes, have you had excessive exposure to noise?
  Yes No
- ❑ Ringing or buzzing in ears
- ❑ Nasal drainage or stuffiness
  If yes, does this occur due to allergies or at random?
  _____
- ❑ Frequent sinusitis
  If yes, how many times in the past six months have you been treated with antibiotics for a sinus infection?
  _____

Lungs

- ❑ Constant or bothersome cough
  If yes, do you cough anything up? Yes No
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Previous exposure to asbestos
- ❑ Asthma or other lung problems

Heart

- ❑ Pain, pressure, heaviness, or tightness in your chest
  If yes, is it with exertion or activity? Yes No
  Does it occur during rest? Yes No
- ❑ Had a stress treadmill test/EKG
- ❑ Abnormal EKG
- ❑ Swelling in feet or hands
- ❑ Heart palpitations or fast or irregular heartbeat

Stomach and Intestines

- ❑ Upset stomach with certain foods
  If yes, what foods? _____
- ❑ Trouble swallowing
- ❑ Indigestion
- ❑ Heartburn
- ❑ Constipation
- ❑ Loose stools or diarrhea
- ❑ Black, tarry, or bloody stools
- ❑ Blood in toilet or on toilet paper

Bladder and Genitals

- ❑ Burning or pain with urination
- ❑ Difficulty starting urine stream
- ❑ Decreased force of urine stream
- ❑ Waking at night to urinate
  If yes, how many times per night? _____
- ❑ Loss of urine with coughing or sneezing
- ❑ Loss of urine with urge to urinate
- ❑ Dribbling urine
- ❑ Bloody urine
- ❑ Treatment for genital infections

Muscles and Bones

- ❑ Arthritis
  If yes, what joints are involved?
  _____
- ❑ Back pain that interferes with activities
- ❑ Joint or muscle pain that limits usual activities

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Nervous System

- ❑ Frequent or severe headaches
  If yes, what are the headaches like? _____
  _____
  How often do they occur? _____
- ❑ Dizziness or vertigo
- ❑ Fainting spells or loss of consciousness
- ❑ Trouble with short-term memory
- ❑ Convulsions, seizures or fits
- ❑ Numbness or tingling in fingers or toes
  If yes, when did it start? _____
  If the cause of this is already known, please state.
  _____

Emotions and Moods

- ❑ Loss of appetite
- ❑ Frequent early morning waking
- ❑ Trouble falling asleep
- ❑ Crying spells
- ❑ Thoughts of killing or harming yourself
- ❑ Nervousness or anxiety

Blood and Lymph

- ❑ Swollen nodes in neck, armpit, or groin
- ❑ Recent infection
  If yes, what and when? _____
  _____
- ❑ Unusual bruising or bleeding

Hormones

- ❑ Abnormal thyroid test results
- ❑ Abnormal blood sugar
- ❑ Loss of sexual desire

Allergies and Infections

- ❑ Environmental allergies such as hay fever or pollen
- ❑ Frequent or numerous infections

(Men Only)

- ❑ Difficulty getting or maintaining an erection
  If yes, how was it treated? _____
- ❑ Discharge from penis
- ❑ Hernia or rupture
- ❑ Prostate problems
- ❑ Change in urinary habits

Date of last prostate exam _____

Who performed exam? _____

What was result? Normal Abnormal

Date of most recent blood prostate level (PSA) test

Date _____

Who performed test? _____

(Women Only)

- ❑ Having menstrual periods
  Regular periods Yes No
  How many days in your cycle? _____
  Heavy periods? Yes No
  Painful periods? Yes No
- ❑ Menopausal
  Date of your last period _____
  Hot flashes? Yes No
  Are you taking hormone replacement? Yes No
  If yes, what kind? _____
  For how long? _____
- ❑ Pregnancies
  How many? _____
  How many by vaginal delivery? _____
  How many by C-section? _____
  How many miscarriages or abortions? _____
- ❑ Taking birth control
  What type? _____
  Current IUD use Yes No

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(Women Only - continued)

- ❑ Lumps in your breasts
- ❑ Discharge from your nipples
- ❑ Annual mammograms

  Date of last mammogram _____

  Were the results normal? Yes No
- ❑ Difficulty achieving orgasm
- ❑ Painful intercourse (sex)
- ❑ Recent treatment for sexually transmitted disease (STD)

Health Maintenance

- ❑ Regular doctor visits with annual physical exam
- ❑ Yearly testing for blood in stool
- ❑ Regular dental exams

  Date of last dental exam _____

  Were fillings or other repair performed? Yes No
- ❑ Regular eye exams

  Date of last eye exam _____
- ❑ Regular exercise

  How many days a week? _____

  What type of exercise? _____

Coping and Tolerance

Have you been depressed since your cancer diagnosis? Yes No

Are you taking antidepressants or other psychiatric medications? Yes No

What helps you relieve stress? _____

_____

What support systems can you and your family count on? (Mark all that apply.)

- ❑ Extended family
- ❑ Friends
- ❑ Church
- ❑ Other (please list) _____

_____

Have you been previously hospitalized in connection with this illness? Yes No

Please describe your hospital experiences to date.

_____

_____

Miscellaneous

- ❑ Trouble keeping track of your medications
- ❑ Forget to take your medications
- ❑ Concerns with paying hospital or medication bills

Is there anything else about your health that you would like us to know?

_____

_____

_____

_____

_____

Thank you for sharing this important information.

Patient Signature _____

Date _____ Time _____

Advanced Practice Clinician/Physician Signature

_____

Date _____ Time _____