Heartland Hematology & Oncology
412 West 42nd Street Kearney, NE 68845
Phone: (308) 865-2303 Fax: (308) 865-2304

Patient information Sheet

DATE _____

Name: _____ Date Of Birth _____ Age _____

Social Security Number _____ Primary Care Physician _____

Referring Physician _____ Primary Dentist _____

Reason for visit: _____

Past Surgeries: _____ Illnesses: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies _____

Medications: _____ _____

_____ _____

_____ _____

Tobacco use: Y/N How many years? _____ Pack/s per day: _____ When did you quit? _____

Alcohol use: Y/N How many drinks per: Day: _____ Week: _____ Month: _____ Year: _____

Married/Single/Widowed/Divorced Occupation: _____

Number of children: _____

Family Medical History:

Family Member	Cancer Diagnosis	Heart Disease	Other Illness

Please complete information on reverse side.

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& Oncology
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Kearney, NE 68845

Patient Name _____

REVIEW OF SYSTEMS

	Y	N	N/A
GENERAL			
Appetite Loss	☐	☐	☐
Weight Loss	☐	☐	☐
Weight Gain	☐	☐	☐
Fever	☐	☐	☐
Chills	☐	☐	☐
Fatigue	☐	☐	☐
Hot Flashes	☐	☐	☐
Night Sweats	☐	☐	☐
Pain Location_____	☐	☐	☐
SKIN			
Bruising	☐	☐	☐
New Lesions	☐	☐	☐
Dryness	☐	☐	☐
Rash	☐	☐	☐
HEENT			
Headache	☐	☐	☐
Visual Disturbances	☐	☐	☐
Hearing Loss	☐	☐	☐
Nasal Congestion	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Mouth Sores	☐	☐	☐
Sore Throat	☐	☐	☐
Bleeding Gums	☐	☐	☐
Double Vision	☐	☐	☐
Dry Eyes	☐	☐	☐
Nose Bleeds	☐	☐	☐
RESPIRATORY			
SOB (shortness of breath)	☐	☐	☐
Cough	☐	☐	☐
Sputum Production	☐	☐	☐
Coughing Up Blood	☐	☐	☐
CARDIOVASCULAR			
Irregular Heart Rhythm	☐	☐	☐
Chest Pain	☐	☐	☐
Edema	☐	☐	☐
Elevated BP	☐	☐	☐
Palpitations	☐	☐	☐
GASTROINTESTINAL			
Heartburn	☐	☐	☐
Abdominal Pain	☐	☐	☐
Blood in Stools	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐

	Y	N	N/A
GENITOURINARY			
Women:			
Age of 1st period _____			
Age of 1st Live Birth _____			
Age of Menopause _____			
Blood in Urine	☐	☐	☐
Incontinence	☐	☐	☐
Times Voiding At Night_____			
Menstruation # of days_____			
Length of Cycle _____			
MEN:			
Incontinence	☐	☐	☐
Hesitancy	☐	☐	☐
Void Frequently	☐	☐	☐
Times Voiding at night	☐	☐	☐
Trouble starting stream	☐	☐	☐
MUSCULOSKELETAL			
Back Pain	☐	☐	☐
Bone Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Pain	☐	☐	☐
Muscle Cramps	☐	☐	☐
NEUROLOGICAL			
Numbness & Tingling	☐	☐	☐
Location_____			
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Unsteadiness	☐	☐	☐
Weakness	☐	☐	☐
PSYCHIATRIC			
Mood Swings	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Inability to Concentrate	☐	☐	☐
Difficulty Sleeping	☐	☐	☐
HEMATOLOGY			
Abnormal Bleeding	☐	☐	☐
History of Blood Clots	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐
Easy Bruising	☐	☐	☐
IMMUNOLOGY			
History of:			
Sinus Infection	☐	☐	☐
Bladder Infection	☐	☐	☐
Pneumonia	☐	☐	☐
Bronchitis	☐	☐	☐