



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

NAME	D.O.B	AGE	SEX	TODAY'S DATE

WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE/ HAVE YOU HAD?								
PROBLEM	YES	NO	COMMENT:					
Cancer/other pre-cancerous lesions								
PROBLEM	YES	NO	PROBLEM	YES	NO	PROBLEM	YES	NO
AIDS/HIV positive			Diabetes			High blood pressure		
Alzheimer's			Emphysema / COPD			Hypo/Hyperthyroid		
Arthritis			Gallstones			Impotence or Infertility		
Asthma			GERD, Reflux, Heartburn			Kidney failure		
Back problems			Heart attack			Lupus or scleroderma		
Blood transfusions			Heart failure			Mononucleosis		
Crohn's disease			Pacemaker			Sexual Transmitted Diseases		
Ulcerative Colitis			High cholesterol			Hepatitis A/B/C		
Stroke or TIAs								
OTHER PROBLEMS:								

SURGERIES [PROVIDE DETAILS INCLUDING APPROXIMATE DATES]

MEDICATION HISTORY: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING [NAME, STRENGTH, FREQUENCY]
1.
2.
3.
4.
5.
6.
7.

ALLERGIES AND OTHER ADVERSE DRUG REACTIONS

List medications you are allergic to or which you have had adverse reactions in the past
(nausea, dizziness, etc)

Medication:			Reaction:		
Have you ever had a reaction to intravenous (IV) contrast? If yes, please describe:	YES	NO	Do you have any seafood allergies? If yes, please describe:	YES	NO
Have you ever had anesthesia?					

CHEMOTHERAPY TREATMENT

If you have met with a chemotherapy doctor please answer the following questions

Chemotherapy name:		
Start/Panned Start Date:	Finished/Planned Finish Date:	

PRIOR RADIATION TREATMENT

If you have had prior radiation treatments, please answer the following questions:

To what part of your body:	Date:
Name of Radiation Oncologist:	Name of Hospital or Center:

FAMILY HISTORY

MOTHER	<input type="checkbox"/> Living at age: <input type="checkbox"/> Deceased at age: <input type="checkbox"/> Unknown	FATHER	<input type="checkbox"/> Living at age: <input type="checkbox"/> Deceased at age: <input type="checkbox"/> Unknown
Medical Problems:		Medical Problems:	
Please list other family history as appropriate below, especially as it relates to history of cancer in any family members:			

OBSTETRIC / GYNECOLOGIC HISTORY (Females)

Age of first period:			Age of menopause:		
Number of Pregnancies:			Number of Births:		
Do you currently or have you ever taken hormone replacement therapy?	YES	NO	Have you had a hysterectomy?	YES	NO

SOCIAL HISTORY

SMOKING	<input type="checkbox"/> Never <input type="checkbox"/> Active <input type="checkbox"/> Quit	# of years:	# packs/day:	Quit how long ago:
ALCOHOL	<input type="checkbox"/> Never <input type="checkbox"/> Active <input type="checkbox"/> Quit	# of years:	# drinks/day:	Quit how long ago:
DRUGS	<input type="checkbox"/> Never <input type="checkbox"/> Active <input type="checkbox"/> Quit	If active/have quit, please describe:		
EMPLOYMENT STATUS	<input type="checkbox"/> Working <input type="checkbox"/> Disability <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	Occupation:	Exposure to chemicals (if yes, which ones):	
MARITAL STATUS	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner			Name of Spouse:

REVIEW OF SYSTEMS

Constitutional:	<input type="checkbox"/> None	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Unintentional weight loss
Eyes:	<input type="checkbox"/> None	<input type="checkbox"/> Abnormal Vision	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Wear Glasses
ENT	<input type="checkbox"/> None	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Frequent Nose Bleeds	<input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Sinus Problems
Cardiovascular:	<input type="checkbox"/> None	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Abnormal Heart Beat
Respiratory:	<input type="checkbox"/> None	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Reduced Exercise Tolerance
Gastrointestinal:	<input type="checkbox"/> None	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
Genitourinary:	<input type="checkbox"/> None	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Hematuria
Neurologic:	<input type="checkbox"/> None	<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Dizziness
Endocrine:	<input type="checkbox"/> None	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Hair/Skin Changes
Musculoskeletal:	<input type="checkbox"/> None	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Joint Pain

ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW