Chad D. Aschtgen, N.D., FABNO
Seattle Integrative Oncology

Institute of Complementary Medicine
Cherry Hill - Jefferson Tower
1600 E. Jefferson St, Ste 603
Seattle, WA 98122

t: 206.726.0034 | f: 206.726.9434

Providence Integrative Cancer Care
at Providence Western Washington Oncology
4525 Third Ave SE, Ste 200
Lacey, WA 98503

t: 360.754.3934 ext: 1083 | f: 360.412.8955

Initial Health History Questionnaire

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

Today's Date:

Last Name: First: Middle:

Age: Date of Birth: Sex: Height: Weight:

Referring Physician/Specialty:

CURRENT HEALTH CONCERNS; *Please list health concerns, symptoms and/or goals in their order of significance to you.*

1.
2.
3.
4.
5.

ONCOLOGY HISTORY

Initial Diagnosis/Tumor Type: Date of Initial Diagnosis (Month/Year):

Any Subsequent Diagnosis/Metastasis: Date:

Date:

Cancer Treatment:

☐ **Surgery:** Date:

Date:

☐ **Radiation:** Date:

Date:

☐ **Chemotherapy:** Date:

Date:

Date:

☐ **Other Therapies:** Date:

Date:

Date:

Office Use Only PWWO MR#:

PERSONAL and FAMILY MEDICAL HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Autoimmune Disease									
Cancer *(Include Type)*									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches/ Migraines									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Osteoporosis									
Seizures									
Stroke									
Thyroid Disease									
Tuberculosis									

Any Serious Injury and/or Accident(s)?

Type:	Date:	Treatment:

PAST SURGICAL HISTORY; patient only

Please list surgical procedures and date; no need to repeat those listed above under the **Oncology History** *section*

Procedure	Date:

Patient Name: ___________________________ *Date of Birth:* _____________

SOCIAL HISTORY and HEALTH HABITS

Current Residence (city, state): [ ] Occupation: [ ]

Domestic Status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do you have any **children**? ❑ Yes ❑ No

Age and gender(s): ______________________

Do you use **tobacco** products? ❑ Yes; ❑ Presently ❑ Past (Quit Date; ____________) ❑ No, never

Form and frequency: ______________________

Do you use any **recreational drugs**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; ____________) ❑ No, never

Form and frequency: ______________________

Do you consume **alcohol**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; ____________) ❑ No, never

Form and frequency: ______________________

Do you have any special **dietary restrictions**? ❑ No ❑ Yes; ______________________

How many servings of **fruit** do you eat daily / weekly (piece or ½ cup)? ____________

How many servings of **vegetables** do you eat daily / weekly (½ cup)? ____________

How many servings of **whole grains** do you eat daily / weekly (slice or ½ cup)? ____________

Do you eat meat? ❑ No ❑ Yes; Fish? ❑ No ❑ Yes; Dairy? ❑ No ❑ Yes____________

How much **water** do you drink on a daily basis (glasses or ounces)? ____________

Do you drink **caffeine**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; ____________) ❑ No, never

Form and frequency: ______________________

Do you use **exercise regularly**? ❑ No ❑ Yes;

Form and frequency: ______________________

How many **hours of sleep** do you get each night on average? _______ Do you wake rested? ❑ No ❑ Yes

Do you have any **trouble falling asleep**? ❑ No ❑ Yes; Or **staying asleep**? ❑ No ❑ Yes;

If yes, please explain: ______________________

Do you have any **significant work or home stress**? ❑ No ❑ Yes;

Please explain: ______________________

Do you feel that you have adequate social support (family, friends, counselor, etc.)? ❑ No ❑ Yes

Do you have any notable current or past toxic exposure(s), either occupational or otherwise? ❑ No ❑ Yes;

Please explain: ______________________

ALLERGIES

☐ **Drug Allergy:** [ ]

☐ **Food Allergy:** [ ]

☐ **Environmental Allergy (mold, dust, hay fever, etc.):** [ ]

CURRENT PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

Medication Name	Dose	Frequency	Reason for Prescription	Prescribing Physician	Start Date (mo/yr)

Any antibiotics use in the last six months? ❑ No ❑ Yes; type: ______________________

Patient Name: ____________________ *Date of Birth:* ____________

CURRENT SUPPLEMENTS

Product Name	Brand	Dose	Frequency	Reason	Prescribing Clinician	Start Date (mo/yr)

REVIEW OF SYMPTOMS; *please mark only current symptoms*

√	Constitutional	√	Gastrointestinal	√	Neurological
	Fatigue		Nausea		Dizziness
	Fever		Vomiting		Headache
	Chills		Constipation		Memory problems
	Night sweats		Diarrhea		Seizures
	Poor appetite		Gas/Bloating		Peripheral neuropathy
	Weight change		Indigestion/Heartburn		Muscle weakness
			Abdominal pain		Tremors
	Ears, Eyes, Nose & Throat		Blood/Mucous in the stool		
	Hair loss		Hemorrhoids		**Hematologic/Lymphatic**
	Changes in vision				Easy bleeding or bruising
	Eye pain		**Genitourinary**		Anemia
	Difficulty hearing		Painful urination		Swelling:
	Ear pain		Difficulty in urination		
	Ringing in ears		Frequent night urination		**Endocrine**
	Change in taste/smell		Blood in urine		Temperature intolerance
	Nasal discharge		Incontinence		Hair, skin or nail changes
	Nose bleeds		Urinary urgency		Altered thirst or hunger
	Throat pain/Sore throat		Urinary frequency		
	Difficulty swallowing		Sexual dysfunction		**Allergic/Immunologic**
			Poor libido		Autoimmune disease history
	Respiratory		Abnormal uterine bleeding		Immune deficiency
	Cough		Painful/Heavy menses		
	Shortness of breath				**Psychiatric**
	Wheezing		**Musculoskeletal:** *location*		Anxiety
			Muscle pain:		Depression
	Cardiovascular		Bone pain:		Irritability/mood changes
	Chest pain		Joint pain:		Sleep disturbance/insomnia
	Palpitations				
	Unusual ankle swelling		**Dermatological/Skin**		**Other:**
	Varicose veins		Rash		
			Eczema		
			Itching		
			Unusual spots/moles		

Patient Name: ____________________________ Date of Birth: ____________

LABORATORY and EXAM HISTORY

Please provide date (month/year) and indicate any abnormal results for each of the following most recent tests

❑ Full physical exam: ________________ ❑ Normal ❑ Other: ______________________________
❑ Blood work: ______________________ ❑ Normal ❑ Other: ______________________________
❑ Cholesterol: ______________________ ❑ Normal ❑ Other: ______________________________
❑ Blood glucose: ____________________ ❑ Normal ❑ Other: ______________________________
❑ Urinalysis: _______________________ ❑ Normal ❑ Other: ______________________________
❑ Hemoccult/Blood in stool: __________ ❑ Normal ❑ Other: ______________________________
❑ Colonoscopy: _____________________ ❑ Normal ❑ Other: ______________________________
❑ DEXA/Bone scan: _________________ ❑ Normal ❑ Other: ______________________________
❑ Eye exam: ________________________ ❑ Normal ❑ Other: ______________________________
❑ Dental exam: ______________________ ❑ Normal ❑ Other: ______________________________

Women Only:

❑ Mammogram: ____________________ ❑ Normal ❑ Other: ______________________________
❑ PAP/Pelvic exam: _________________ ❑ Normal ❑ Other: ______________________________

Men Only:

❑ Prostate Exam: ___________________ ❑ Normal ❑ Other: ______________________________
❑ PSA: ____________________________ ❑ Normal ❑ Other: ______________________________

PHYSICIAN TEAM

Medical Oncologist *Providence Western Washington Oncology?* ❑ Yes ❑ No

Physician Name: Clinic/Facility Name:
Phone Number: Clinic Address:
Fax Number:

Surgeon/Surgical Oncologist

Physician Name: Clinic/Facility Name:
Phone Number: Clinic Address:
Fax Number:

Radiation Oncologist *Radiant Care Radiation Oncology?* ❑ Yes ❑ No

Physician Name: Clinic/Facility Name:
Phone Number: Clinic Address:
Fax Number:

Internal Medicine/General Care/Family Physician

Physician Name: Clinic/Facility Name:
Phone Number: Clinic Address:
Fax Number: