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Health History Questionnaire

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

Last Name: _____ First: _____ Middle: _____

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

Referring Physician & Specialty: _____

CURRENT PHYSICIAN TEAM

Medical Oncologist: _____ Clinic/Facility Name: _____

Surgeon/ Surgical Oncologist: _____ Clinic/Facility Name: _____

Radiation Oncologist: _____ Clinic/Facility Name: _____

General/ Family Physician: _____ Clinic/Facility Name: _____

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

1. _____
2. _____
3. _____
4. _____

ONCOLOGY HISTORY

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

Any Subsequent Diagnosis/Metastasis: _____ Date: _____

Cancer Treatment:

Initial Therapy: _____ Date: _____

Secondary Therapy: _____ Date: _____

Additional Therapy: _____ Date: _____

_____ Date: _____

_____ Date: _____

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

CURRENT SUPPLEMENTS

Product Name	Brand	Dose	Frequency	Reason	Prescribing Clinician	Start Date

FAMILY HISTORY of CANCER

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

Type of Cancer: _____ Relative: _____

Type of Cancer: _____ Relative: _____

Type of Cancer: _____ Relative: _____

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 – Years of Use: _____ ❑ No, never

Form(s); ❑ Cigarettes, ❑ Chewing, ❑ Vaping. Frequency (e.g. packs per day): _____

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(s); ❑ Beer, ❑ Wine, ❑ Spirits. Frequency: _____

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

Do you eat **vegetables** daily? ❑ No ❑ Yes; **Fruit**? ❑ No ❑ Yes; **Whole grains**? ❑ No ❑ Yes

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: **coffee** / **tea** / **soda pop** 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**? ❑ Low ❑ Medium ❑ High;

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: _____

PERSONAL MEDICAL HISTORY

Please place a "C" for current or "P" for past on the line next to each condition as it applies to your health history.

___ ADD/ ADHD
___ AIDS/ HIV
___ Allergies/ Hay Fever
___ Anemia
___ Anxiety Disorder
___ Arthritis
___ Asthma
___ Autoimmune Disease
___ BRCA 1 or 2 positive
___ Birth Defects or Inherited Dz
___ Bladder or Kidney Problems
___ Blood Disease or bleeding Disorder
___ Cancer
Type: _____
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ Ear or Hearing Problems
___ Eating Disorder
___ Eczema
___ GI Problems
___ Gout
___ Headaches
___ Heart Disease
___ Hepatitis
___ High Cholesterol
___ Hypertension
___ Kidney Disease
___ Liver Disease
___ Lung Disease
___ Mental Illness
___ Muscle, Joint or Bone Problem
___ Neurological Disease
___ Obesity
___ Osteoporosis
___ Prostate Problems
___ Pulmonary Embolism/ DVT
___ Reflux/ GERD
___ Seizures/ Epilepsy
___ Skin Problems
___ Sleep Apnea
___ Stroke
___ Thyroid Problems
___ Vision or Eye Problems

Other:
_____
_____
_____

PAST SURGICAL HISTORY

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

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

REVIEW OF SYMPTOMS; *please mark only current symptoms*

√ Constitutional
___ Energy level; *rate 1-10* ___ /10
___ Poor appetite
___ Pain; *rate 1-10* ____ /10
___ Fever
___ Chills
___ Night sweats
___ Weight loss / gain; ____ lbs
___ Exercise intolerance

√ Head
___ Hair loss

√ Eyes
___ Dry eyes
___ Eye irritation
___ Changes in vision
___ Excess tearing

√ Ears, Nose Mouth & Throat
___ Difficulty hearing
___ Ear pain
___ Ringing in ears
___ Nasal discharge
___ Nosebleeds
___ Nasal congestion
___ Throat pain/Sore throat
___ Change in taste or smell
___ Dry mouth
___ Mouth sores
___ Bleeding gums
___ Teeth abnormalities
___ Hoarseness of voice

√ Respiratory
___ Cough
___ Wheezing
___ Shortness of breath
___ Coughing up blood
___ Sleep apnea

√ Cardiovascular
___ Chest pain
___ Palpitations
___ Light-headed at standing
___ Short of breath walking
___ Heart murmur
___ Varicose veins

√ Gastrointestinal
___ Difficulty swallowing
___ Heartburn/ GERD
___ Indigestion/ Dyspepsia
___ Gas/Bloating
___ Abdominal pain/ cramping
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Blood/Mucous in the stool
___ Hemorrhoids

√ Genitourinary
___ Urinary urgency
___ Urinary frequency
___ Painful urination
___ Blood in urine
___ Urinary incontinence
___ Difficulty in urination
___ Frequent night urination
___ Erectile dysfunction
___ Poor libido
___ Flank pain
___ Vaginal dryness
___ Vaginal pain
___ Painful/Heavy menses

√ Musculoskeletal *Location:*
___ Muscle ache: _____
___ Muscle weakness
___ Joint pain: _____
___ Back pain
___ Swelling in extremities
___ Muscle cramps
___ Bone pain: _____

√ Dermatological/Skin
___ Rash
___ Unusual growth or lesion
___ Jaundice
___ Acne
___ Itching
___ Eczema
___ Poor wound healing

√ Neurological
___ Headache
___ Migraines
___ Dizziness
___ General malaise/weakness
___ Memory recall poor
___ Loss of consciousness
___ Numbness and/or tingling
___ Seizures
___ Tremors

√ Hematologic/Lymphatic
___ Enlarged/swollen glands
___ Easy bruising or bleeding

√ Endocrine
___ Fatigue
___ Hot flashes
___ Increased thirst
___ Cold intolerance
___ Increased hair growth

√ Allergic/Immunologic
___ Runny nose
___ Sinus pressure
___ Hives
___ Frequent sneezing

√ Psychiatric
___ Depression
___ Anxiety
___ Irritability/mood changes
___ Alcohol/drug abuse
___ Suicidal thoughts

√ Other:
_____
_____
_____
_____
_____
_____