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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.

- _____
- _____
- _____
- _____

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.

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

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:**
