 PATIENT QUESTIONNAIRE

**Please bring completed to appointment with photo ID and insurance card(s)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Biopsy** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Facility (St. Mary, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Oncologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plastic Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other physicians involved in your overall medical or cancer care (GI, Pulmonologist, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Recent Imaging Studies (Please list approximate dates and facility):** | | | |
| \_\_ Mammogram | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ PET/CT | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ CT Scan | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ MRI | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_ Other \_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ Ultrasound | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Have you had:**

1. Chemotherapy? No\_\_ Yes\_\_ If yes, last infusion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Chemotherapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Hormone therapy? No\_\_ Yes\_\_ If yes, when did it start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Radiation therapy? No\_\_ Yes\_\_ If yes, approx dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area of body treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list:**

|  |  |
| --- | --- |
| **Medical Conditions:** | **Past Surgeries and Dates:** |
| 1. | 1. Date: |
| 2. | 2. Date: |
| 3. | 3. Date: |
| 4. | 4. Date: |
| 5. | 5. Date: |

**Family History (Blood Relatives):**

1. Any family members with cancer history? No \_\_\_ Yes \_\_\_ If yes, please list relation and type of cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Father: \_\_\_Alive, Age\_\_\_\_ or \_\_\_Deceased, Age\_\_\_ cause\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Mother: \_\_\_Alive, Age\_\_\_\_ or \_\_\_Deceased, Age\_\_\_ cause\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

1. Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently employed? No\_\_\_\_ Yes\_\_\_\_
2. Marital status: \_\_ Married, \_\_Single, \_\_Widow/Widowed, \_\_Divorced,

\_\_Significant Other

1. Children: No\_\_\_ Yes\_\_\_ If yes, how many and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Who do you live with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Hobbies/interests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you drink alcohol? No\_\_\_ Yes\_\_\_ how many drinks per week? \_\_\_\_Type of alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink caffeine? No\_\_\_\_ Yes\_\_\_\_
4. \_\_\_ Never Smoked

\_\_\_ Active Smoker, How many packs of cigarettes per day? \_\_\_\_\_\_\_# of years\_\_\_\_\_\_\_

\_\_\_ Former Smoker, How many packs of cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Quit how many years ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any history of drug abuse/addiction? No\_\_\_ Yes\_\_\_ Type of drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Autoimmune diseases? No\_\_\_ Yes\_\_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Inflammatory bowel disorders? No\_\_\_ Yes\_\_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Radon, asbestos, or other exposures? No\_\_\_ Yes\_\_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Assistive device/mobility: Cane\_\_\_ Walker\_\_\_ Wheelchair\_\_\_
6. Do you have transportation? No\_\_\_ Yes\_\_\_

Do you have a living will? No\_\_Yes\_\_

Do you have a durable power of attorney? No\_\_\_ Yes\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you CURRENTLY have any of the following conditions or symptoms (Check all that apply):**

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL**  \_\_ Fatigue  \_\_ Fever  \_\_ Weight Gain >10 lbs  \_\_ Weight Loss >10 lbs  \_\_ Chills  \_\_ Night Sweats  \_\_ Trouble Sleeping  **SKIN**  \_\_ History skin cancer  \_\_ Open wounds  \_\_ Nail changes  \_\_ New lesions  \_\_ Rash  \_\_ Skin color changes  **HEENT**  \_\_ Double vision  \_\_ Eye pain  \_\_ Decreased vision  \_\_ Decreased hearing  \_\_ Earache/ear ringing  \_\_ Nose bleeds  \_\_ Dry mouth  \_\_ Hoarseness  \_\_ Oral ulcers  \_\_ Sore throat  \_\_ Pain when swallowing  Date of last dental exam:\_\_\_\_\_\_\_\_\_\_\_\_  **HEMATOLOGY**  \_\_ Easy bruising  \_\_ Enlarged lymph nodes  \_\_ Prolonged bleeding  **PAIN**  Do you have pain? No\_\_\_ Yes\_\_\_  Location:\_\_\_\_\_\_\_\_\_\_  Describe:\_\_\_\_\_\_\_\_\_\_ | **RESPIRATORY**  \_\_ Chronic cough  \_\_ Shortness of breath  \_\_ Decreased exercise   tolerance  \_\_ Difficulty breathing  \_\_ Coughing up blood  \_\_ Sputum production  \_\_ Wheezing  **BREAST**  \_\_ Breast mass  \_\_ Breast pain  \_\_ Nipple discharge  \_\_ Nipple inversion  Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CARDIOVASCULAR**  \_\_ Heart disease  \_\_ Chest pain  \_\_ Leg pains with walking  \_\_ Leg swelling  \_\_ Night awakening due   to trouble breathing  \_\_ Palpitations  \_\_ Pacemaker/defibrillator  **ENDOCRINE**  \_\_ Appetite changes  \_\_ Cold intolerance  \_\_ Increased thirst  \_\_ Hair changes  Pain scale:  0 1 2 3 4 5 6 7 8 9 10 | **GENITOURINARY**  Are you sexually active?   \_\_Y \_\_N  \_\_ Difficulty starting/   stopping urinary stream  \_\_ Painful urination  \_\_ Change in urinary stream  \_\_ Increased frequency  \_\_ Blood in urine  \_\_ Loss of bladder control  \_\_ Nighttime urination  \_\_ Urinary retention  **FEMALES ONLY**  \_\_ Vaginal discharge  \_\_ Menstrual irregularities  Age of first period\_\_\_\_\_\_\_\_  Age of first pregnancy\_\_\_\_\_  Are you pregnant? \_\_Y \_\_N  Number of pregnancies\_\_\_\_  Did you breast feed? \_\_ Y\_\_N  Did you ever take birth control?\_\_ Y \_\_N  Did you ever take hormone/fertility treatment? \_\_ Y \_\_N  Date of last GYN exam:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last pap smear:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Breast Cancer Patients**  Bra size:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MALES ONLY**  \_\_ Impotence  \_\_ Testicular pain  \_\_ Enlarged prostate  \_\_Previous biopsy | **MUSCULOSKELETAL**  \_\_ Decreased range of   motion  \_\_ Joint swelling  \_\_ Muscle aches/pains  \_\_ Back pain  \_\_ Bone pain  \_\_ Balance difficulty  \_\_ Fallen recently  \_\_ Weakness  \_\_ Arthritis  **NEUROLOGICAL**  \_\_ Loss of bowel control  \_\_ Dizziness/vertigo  \_\_ Headaches  \_\_ Numbness/tingling  \_\_ Passing out  \_\_ Seizures  \_\_ Tremor  \_\_ Memory problems  **GASTROINTESTINAL**  \_\_ Abdominal pain  \_\_ Change in bowel   habits  \_\_ Constipation  \_\_ Diarrhea  \_\_ Nausea  \_\_ Vomiting  \_\_ Gastric reflux  \_\_ Rectal bleeding  \_\_ Trouble swallowing  Date of last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PSYCHIATRIC**  \_\_ Anxiety  \_\_ Depression  \_\_ Hallucinations  \_\_ Suicidal thoughts |

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

A picture containing text

Description automatically generated **Patient Medication List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name:** | | | | **Date of Birth:** |
| **Primary Pharmacy:** | | | | **Pharmacy Phone Number:** |
| **PLEASE LIST ALL OF YOUR ALLERGIES** | | **TYPE OF REACTION** | | |
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|  | |  | | |
| Please list all of your medications:  Prescription, over-the-counter medications, vitamins, **and** herbal supplements | | | | |
| **NAME OF MEDICATION** | **DOSE** | | **FREQUENCY** | |
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