 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):**

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| **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 swallowingDate 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 inversionDate 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 changesPain 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 irregularitiesAge of first period\_\_\_\_\_\_\_\_Age of first pregnancy\_\_\_\_\_Are you pregnant? \_\_Y \_\_NNumber of pregnancies\_\_\_\_Did you breast feed? \_\_ Y\_\_NDid 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 swallowingDate of last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PSYCHIATRIC**\_\_ Anxiety\_\_ Depression\_\_ Hallucinations\_\_ Suicidal thoughts |

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

 **Patient Medication List**

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| **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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