PATIENT HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Date: ___________________________

Last Name __________________ First Name _______________ Middle _________________

Age _______ Sex _______ Marital Status _________ SS# ___________________________

Personal Physician: ____

Referring Physician (if different): ____

INSTRUCTIONS

Please answer carefully the enclosed questionnaire about your present and past medical problems and the history of your current illness. It is important that you complete each of the questions as accurately as possible so the doctor can best understand the nature of your present medical problems.

This information will become part of your permanent medical records and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

HISTORY OF PRESENT ILLNESS

PHYSICIAN COMMENTS

Why did your doctor send you to CBCC for this consultation - chief complaint?

____
____
____
____

Did you discover the medical problem? Yes [ ] No [ ]

Did your doctor find it? Yes [ ] No [ ]

Have you been treated for this problem? Yes [ ] No [ ]
If yes, please give the date and location of the treatment/surgery:

Surgery:

Radiation:

Drug or other therapy (Chemotherapy):

Briefly describe your current medical problem. List symptoms and how long you have had them:

____
____
____
____

Do you have other medical problems that are now being treated? Yes[ ] No[ ]
If yes, please list them here:

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

PAST MEDICAL HISTORY

Please circle the illnesses that you have had. Provide the year for those needing hospitalization:

____Heart Disease	____Scarlet Fever	____Recurrent Pneumonia
____Cancer	____Hepatitis	____Kidney Disease
____Diabetes	____Stomach Ulcer	____Recurrent Bronchitis
____Emphysema	____Peptic Ulcer	____Venereal Diseases
____Hives	____Liver Disease	____Nervous Breakdown
____Asthma	____Jaundice	____Bleeding Disorder
____Tuberculosis	____Measles	____Rheumatic Fever
____Valley Fever	____Mumps	____High Blood Pressure
____Blood Clots	____Chicken Pox	____Shingles/Herpes Zoster
____Seizures	____ Anemia	____Thyroid Disease
		____Any other serious illness

PHYSICIAN COMMENTS

Have you had any of the surgeries listed below? Please circle and give the year:

Appendix	_____	Artery	_____	Heart Problems	_______
Breast	_____	Colon	_____	Heart Surgery	_______
Eyes	_____	Gallbladder	_____	Hernia Repair	_______
Hip	_____	Knee	_____	Prostate Gland	_______
Lung	_____	Mastoids	_____	Thyroid Gland	_______
Ovary	_____	Nose	_____	Hemorrhoids	_______
Kidney	_____	Tubes Tied	_____	Tonsil & Adenoids	_______
Veins	_____	Uterus	_____	Dilatation & Curettage	____
Bone Marrow	_____	Bladder	_____		
Stomach	_____	Any Other	_____________________________		

Have you ever had problems with anesthesia? Yes [ ] No [ ]
If yes, please state type of problem:

Have you ever had a blood transfusion? Yes [ ] No [ ]
If yes, Month ______ Year ______

Have you ever had a radiation treatment? Yes [ ] No [ ]
If yes, what part(s) of the body?

Have you had serious accidents or injuries? Yes [ ] No [ ]
If yes, please describe the accident or injury:

Please list the names of any Medications that you take regularly:

NAME	DOSE/ FREQUENCY	DATE STARTED	PHARMACY

Would you like to have some of your prescriptions filled at our office?
Yes [ ] No [ ]

Please list any Allergies you have:

Medication/Food	Reaction	Date First Occurred

PERSONAL HABITS (FOR EVERYONE)

PHYSICIAN COMMENTS

Please list the jobs that you have held: ______________________________
____
____

Have you ever been exposed to any of the following?

Radiation	Yes [ ]	No [ ]	Insecticides	Yes [ ]	No [ ]
Petroleum Products	Yes [ ]	No [ ]	Benzene	Yes [ ]	No [ ]
Industrial Toxins	Yes [ ]	No [ ]			

Smoking:

[ ] Yes – current every day smoker
[ ] Yes – current some day smoker   # Years ______
[ ] Yes – smoker   # Packs/Day ______
[ ] Yes – But quit   Years Quit ______
[ ] Never

Do you drink alcohol?   Yes [ ]   No [ ]
If yes, list amount and type: ___________________________________
____

Have you been on a diet in the past?   Yes [ ]   No [ ]
If yes, list type of diet and the reason: ____________________________
____

Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)
Yes [ ]   No [ ]

RELIGIOUS BELIEFS (OPTIONAL)

Do you have a religious background?   Yes [ ]   No [ ]
If yes, please explain:
____
____

Do you think your religious beliefs have or will play any important role in your illness and treatment?   Yes [ ]   No [ ]

Would you like a doctor, nurse, or other staff member to pray with you?
Yes [ ]   No [ ]

CANCER SCREENING

Have you had any of the following screening tests? If yes, when and where?

Type of Test	Yes	No	When	Where
Mammogram	___	___	__________	________________
Pap Smear	___	___	__________	________________
Prostate Exam	___	___	__________	________________
PSA	___	___	__________	________________
Colon Exam	___	___	__________	________________
Skin Exam	___	___	__________	________________
Chest x-ray	___	___	__________	________________

Has any member of your family had cancer?   Yes ____   No ____

If yes, please see next page and list others here: ____________________
____

FAMILY HISTORY – GENERAL

PHYSICIAN COMMENTS

Please list the members of your immediate family, their ages, current health status, and if deceased, their cause of death.

Immediate Family Member	Age	Health Status			Cause of Death And Age
		Good	Fair	Poor	
Mother					
Father					
Sister(s)					
Brother(s)					
Daughter(s)					
Son(s)					

Has any family member had a blood disease? Yes [ ] No [ ]
If yes, please list relationship and type of blood disease.

Do any of the following conditions run in your family?

Twins Yes [ ] No [ ]
Birth defects Yes [ ] No [ ]
Tumors Yes [ ] No [ ]

Are you a twin? Yes [ ] No [ ]

Were you born with a birth defect? Yes [ ] No [ ] Please explain:

Additional comments:

FAMILY HISTORY FOR CANCERS

Place a check mark (√) in the boxes below for yourself and each family member who has had a cancer diagnosis as indicated.

Immediate Family Members	Breast Cancer Before Age 50	Breast Cancer After Age 50	Colon Cancer Before Age 50	Colon Cancer After Age 50	Endometrial Cancer Before Age 50	Endometrial Cancer After Age 50	Ovarian Cancer at Any Age	Other Cancers at Any Age List Type
Yourself								
Mother								
Father								
Sister(s)								
Brothers(s)								
Daughter(s)								
Son(s)								
MOTHER'S SIDE								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								
FATHER'S SIDE								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								

Any males with breast cancer at any age.

REVIEW OF SYSTEMS

PHYSICIAN COMMENTS

Do you have, or have you had in the past 6 months, any of the following. Please **circle**.

General weakness	Fever of unknown cause	Night sweats
Skin rashes	Weight loss without cause	Chills
Change in taste	Enlarging moles	Loss of appetite
Sores not healing		

Do you have frequent/recurrent headaches?	Yes [ ]	No [ ]
Do you have frequent dizzy spells?	Yes [ ]	No [ ]
Have you ever fainted?	Yes [ ]	No [ ]
Have you had a recent change in eyesight?	Yes [ ]	No [ ]
Have you had recent change in hearing?	Yes [ ]	No [ ]
Do you have ringing or roaring in your ears?	Yes [ ]	No [ ]
Do you wear dentures?	Yes [ ]	No [ ]
Do they fit properly?	Yes [ ]	No [ ]
Do you have frequent sore throats?	Yes [ ]	No [ ]
Do you have trouble swallowing?	Yes [ ]	No [ ]
Do you have hoarseness without colds?	Yes [ ]	No [ ]
Have you lumps or swelling in the neck?	Yes [ ]	No [ ]
Do you cough up a lot of phlegm?	Yes [ ]	No [ ]
Have you coughed up blood?	Yes [ ]	No [ ]
Do you have coughing spells?	Yes [ ]	No [ ]
Do you get short of breath without exercise?	Yes [ ]	No [ ]
With exercise?	Yes [ ]	No [ ]
Have you had pains in your chest?	Yes [ ]	No [ ]
Have you been treated for heart problems?	Yes [ ]	No [ ]
Have you had high blood pressure?	Yes [ ]	No [ ]
Have you had thumping or racing heart?	Yes [ ]	No [ ]
Do your ankles swell?	Yes [ ]	No [ ]
Do you have frequent indigestion?	Yes [ ]	No [ ]
Do you have pain in your stomach?	Yes [ ]	No [ ]
Have you had frequent nausea or vomiting?	Yes [ ]	No [ ]
Have you ever vomited blood?	Yes [ ]	No [ ]
Have you had black bowel movements?	Yes [ ]	No [ ]
Have your bowel movements changed in the last 6 months?	Yes [ ]	No [ ]
Have you had blood in your bowel movements?	Yes [ ]	No [ ]
Do you notice burning on urination?	Yes [ ]	No [ ]
Do you get up every night to urinate?	Yes [ ]	No [ ]
Have you passed blood in your urine?	Yes [ ]	No [ ]
Have you passed a kidney stone?	Yes [ ]	No [ ]
Have you had root beer colored urine?	Yes [ ]	No [ ]
Any change in your desire for sexual activity?	Yes [ ]	No [ ]

PHYSICIAN COMMENTS

Have you noticed any change in your ability to engage in sexual activity?	Yes [ ]	No [ ]
Do you have joint trouble?	Yes [ ]	No [ ]
Do you have constant back pain?	Yes [ ]	No [ ]
Do you have constant bone pain?	Yes [ ]	No [ ]
Do you bruise easily?	Yes [ ]	No [ ]
Do you bleed easily?	Yes [ ]	No [ ]
Do your gums bleed frequently?	Yes [ ]	No [ ]
Do you have prolonged bleeding with cuts?	Yes [ ]	No [ ]
Do you have frequent nosebleeds?	Yes [ ]	No [ ]
Do you have feelings of sadness, depression, or anxiety?	Yes [ ]	No [ ]

FOR MEN ONLY

Do you have trouble urinating?	Yes [ ]	No [ ]
Have you been told you have prostate problems?	Yes [ ]	No [ ]
Have you been circumcised?	Yes [ ]	No [ ]

FOR WOMEN ONLY

How old were you when you began menstruating? ___________
How old were you when you first became pregnant? ___________
Do you still have periods? Yes [ ] No [ ]
If yes, please indicate date of last period: _______________
If no, please list reason: Natural [ ] Surgery [ ]
Have you ever taken birth control pills? Yes [ ] No [ ]
Have you ever taken hormones? Yes [ ] No [ ]
When was your last pap smear? _______________________
Do you bleed between your periods? Yes [ ] No [ ]
Last mammogram: Date ___________ Where? _______________________
Breast self exam? Yes [ ] No [ ]
Nipple discharge? Yes [ ] No [ ]
Palpable lumps? Yes [ ] No [ ]
Change in size or shape of nipples/breast? Yes [ ] No [ ]

Please indicate the following:

Number of pregnancies	_____	Number of cesareans	_____
Number of miscarriages	_____	Number of stillborn	_____
Number of premature births	_____	Number of abortions	_____
Number of children born alive	_____		

Have you had any complications of pregnancy? Yes [ ] No [ ]
____
____
____
____