

Patient Health & Medical History Questionnaire

Date: _____

First Name: _____ Date of Birth: _____

Middle Name: _____ Ethnicity/Race: _____

Last Name: _____ Marital Status: _____

Sex: Male Female

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 records and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

List Your Physician(s)

Use additional pages if needed. Check box if provider is to receive a copy of today's consultation.

Personal Physician: _____ Phone: _____

Surgeon: _____ Phone: _____

Cardiologist: _____ Phone: _____

Pulmonologist: _____ Phone: _____

Urologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Other: _____ Phone: _____

Your Pharmacy

Name: _____ Phone: _____

CBCC COMPREHENSIVE
BLOOD & CANCER CENTER
Outsmarting Cancer™

(661) 322-2206 main | (661) 322-7027 fax | 6501 Truxtun Avenue, Bakersfield, CA 93309 | www.cbccusa.com

A Jonsson Comprehensive Cancer Center TRIO-US Site

Medications

Physician Comments

List the names of any medications that you take regularly:

Name:	Dose:	Frequency:	Date Started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Allergies

Medication/Food:	Reaction:	Date First Occurred:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of Present Illness

What is the reason for your visit? _____

What are your current symptoms and how long have you had them? _____

Have you received treatment for this diagnosis?

No Yes. Please give date and location of the treatment/surgery:

Surgery: _____

Radiation: _____

Drug or other therapy (chemotherapy): _____

Do you have other medical problems that are now being treated?

No Yes. Please list them here:

Past Medical History

Physician Comments

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Bronchitis (<i>Recurring</i>) _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stomach Ulcer _____ | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Nervous Breakdown _____ |
| <input type="checkbox"/> Hives _____ | <input type="checkbox"/> Jaundice _____ | <input type="checkbox"/> Bleeding Disorder _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Valley Fever _____ | <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Shingles _____ |
| <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Herpes Zoster _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Pneumonia (<i>Recurring</i>) _____ | <input type="checkbox"/> Thyroid Disease _____ |

Other serious illness: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Stomach _____ | <input type="checkbox"/> Bladder _____ |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Artery _____ | <input type="checkbox"/> Heart Problems _____ |
| <input type="checkbox"/> Eyes _____ | <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Heart Surgery _____ |
| <input type="checkbox"/> Hip _____ | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Hernia Repair _____ |
| <input type="checkbox"/> Lung _____ | <input type="checkbox"/> Knee _____ | <input type="checkbox"/> Prostate Gland _____ |
| <input type="checkbox"/> Ovary _____ | <input type="checkbox"/> Mastoids _____ | <input type="checkbox"/> Thyroid Gland _____ |
| <input type="checkbox"/> Kidney _____ | <input type="checkbox"/> Nose _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Veins _____ | <input type="checkbox"/> Tubes Tied _____ | <input type="checkbox"/> Tonsil & Adenoids _____ |
| <input type="checkbox"/> Bone Marrow _____ | <input type="checkbox"/> Uterus _____ | <input type="checkbox"/> Dilatation & Curettage _____ |

Other surgeries: _____

Have you ever had problems with anesthesia?

- No Yes: Please state the problem: _____

Have you ever had radiation treatment?

- No Yes: What part(s) of the body: _____

Have you ever had serious accidents or injuries?

- No Yes: Please describe: _____

Have you ever had a blood transfusion?

- No Yes: Month: _____ Year: _____

Cancer Screening

Physician Comments

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

Mammogram No Yes When: _____ Where: _____
 Pap Smear No Yes When: _____ Where: _____
 Prostate Exam No Yes When: _____ Where: _____
 PSA No Yes When: _____ Where: _____
 Colon Exam No Yes When: _____ Where: _____
 Skin Exam No Yes When: _____ Where: _____
 Chest X-Ray No Yes When: _____ Where: _____
 Other: _____ When: _____ Where: _____

General Family History

List the members of your immediate family, their ages, current health status and if deceased, their age of death.

	Age	Health Status			Cause of Death & Age
		Good	Fair	Poor	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Are you of Ashkenazi Jewish heritage? No Yes

Has any family member had a blood disease?

No Yes: List relationship and type of blood disease: _____

Do you have any birth defects in your family history?

No Yes: Please explain: _____

Are you a twin? No Yes

Where you born with a birth defect?

No Yes: Please explain: _____

Cancer Family History

Physician Comments

Write in the **age** of each cancer diagnosis in the box below for yourself and each family member who has been diagnosed with cancer as indicated.

	Breast Cancer	Male Breast Cancer	Colon Cancer	Prostate Cancer	Pancreatic Cancer	Endometrial Cancer	Ovarian Cancer	Other <i>Fill in cancer type & age diagnosed.</i>
Yourself								
Mother								
Father								
Sister(s)								
Brother(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)								

Family history unknown.

Personal Habits

Physician Comments

List the jobs you have held: _____

Have you ever been exposed to any of the following?

- Radiation No Yes
Petroleum Products No Yes
Industrial Toxins No Yes
Insecticides No Yes
Benzene No Yes

Smoking:

- Yes, current every day smoker. Number of years: _____ Packs per day: _____
 Yes, occasional smoker. Number of years: _____ Packs per week: _____
 Previously smoked, but quit. Years quit: _____
 Never smoked

Do you drink alcohol? No Yes: List amount & type: _____

Have you been on a diet in the past? No Yes: List type and reason: _____

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

Religious Beliefs (optional)

Do you have a religious background? No Yes: Explain: _____

Will your religious beliefs have an important role in your treatment? No Yes

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

Review of Systems

Do you have, or have you had **in the last 6 months**, any of the following?

- | | |
|---------------------------|--|
| General weakness | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Skin rashes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Change in taste | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sores not healing | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fever of unknown cause | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Weight loss without cause | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Enlarging moles | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Night sweats | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chills | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Loss of appetite | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Review of Systems (cont.)

Physician Comments

Do you **currently** have any of the following?

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

Review of Systems (cont.)

Physician Comments

- Do you have joint trouble? No Yes
-
- Do you have constant back pain? No Yes
-
- Do you have constant bone pain? No Yes
-
- Do you bruise easily? No Yes
-
- Do you bleed easily? No Yes
-
- Do your gums bleed frequently? No Yes
-
- Do you have prolonged bleeding with cuts? No Yes
-
- Do you have frequent nosebleeds? No Yes
-
- Do you have feelings of sadness, depression or anxiety? No Yes

FOR MEN ONLY

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

Breast Health History (Women Only)

- Do you conduct breast self exams? No Yes
- Do you feel palpable lumps? No Right Left Both
- Do you have nipple discharge? No Right Left Both
- Do you have nipple inversion? No Right Left Both
- Has the size or shape of the nipples changed? No Right Left Both
- Have you had any breast trauma? No Right Left Both
- Have you had any breast cyst aspirated? No Right Left Both
- Do you feel breast pain? No Right Left Both
- If yes, is the pain related to periods? No Yes
- Have you had any prior breast surgery? No Yes

Type of surgery: Biopsy Lumpectomy Mastectomy

If yes, check which side and list diagnosis year and where the surgery was performed:

Left Diagnosis, list year: _____, where: _____

Right Diagnosis, list year: _____, where: _____

Gynecologic History (Women Only)

Physician Comments

Have you ever taken hormones? No Yes

If yes, give type: _____ Duration: _____ Stopped: _____

Have you ever taken birth control pills? No Yes

If yes, when were they started? _____ When were they stopped? _____

How old were you when you began menstruating? _____

Do you bleed between your periods? No Yes

Do you still have periods?

Yes, indicate date of first day of last period: _____

No, check reason: Natural, at what age? _____ Surgery, at what age? _____

Are you currently pregnant? No Yes

Are you interested in having more children? No Yes

Age when you first became with your first full-term pregnancy? _____

Have you had any complications of pregnancy? No Yes, describe: _____

Did you breast feed? No Yes, for _____ months.

Please indicate the following:

Number of pregnancies: _____ Number of premature births: _____

Number of cesareans: _____ Number of abortions: _____

Number of miscarriages: _____ Number of children born alive: _____

Number of stillborn: _____