Patient Name: ___________________________________

Date of Birth: ___________ **Today's Date:** ____________

Reason for Visit: _________________________________

MISSOURI CANCER ASSOCIATES

There for you, every step of the way

Health Questionnaire

PAST MEDICAL HISTORY

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (√) in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	Medical Problem	Surgery	Year(s) of Surgery	Describe
Eyes (cataracts, glaucoma)	☐	☐	_______	______________________________
Ears, nose, sinuses, or tonsils	☐	☐	_______	______________________________
Thyroid or parathyroid glands	☐	☐	_______	______________________________
Heart disease	☐	☐	_______	______________________________
Atrial fibrillation	☐	☐	_______	______________________________
Coronary (heart) arteries (angina)	☐	☐	_______	______________________________
Arteries (aorta, arteries to head, arms, legs)	☐	☐	_______	______________________________
Veins or blood clots in the veins	☐	☐	_______	______________________________
Lungs	☐	☐	_______	______________________________
Esophagus or stomach (ulcer)	☐	☐	_______	______________________________
Bowel (small & large intestine) or appendix	☐	☐	_______	______________________________
Liver or gallbladder (including hepatitis)	☐	☐	_______	______________________________
Pancreas	☐	☐	_______	______________________________
Hernia	☐	☐	_______	______________________________
Lymph nodes or spleen	☐	☐	_______	______________________________
Kidneys or bladder	☐	☐	_______	______________________________
Bones, joints or muscles	☐	☐	_______	______________________________
Back, neck or spine	☐	☐	_______	______________________________
Brain	☐	☐	_______	______________________________
Skin	☐	☐	_______	______________________________
Breasts	☐	☐	_______	______________________________
Females: uterus, tubes, ovaries	☐	☐	_______	______________________________
Males: prostate, penis, testes, vasectomy	☐	☐	_______	______________________________

Patient Initials/Date of Birth: ______________

Female Patients Only:

Have you ever taken birth control pills or hormone replacement? □ No □ Yes

Have you experienced menopause or had a hysterectomy? □ No □ Yes

If no: Are you concerned about your menstrual periods? □ No □ Yes

Might you be pregnant at this time? □ No □ Yes

Date of onset of your last menstrual period: mo: ______ yr: ______

Approximate date of your last Pap smear and pelvic exam: mo: ______ yr: ______ □ Never

Age at first menstrual period: _____ Age at first pregnancy: ______ Number of pregnancies: _____ Live births: _____

PERSONAL HISTORY

Have you ever had any of the following:	YES	Describe the problem when appropriate:
Anxiety, depression or mental illness	□	____
Autoimmune disease (Lupus, Rheumatoid arthritis, etc.)	□	____
Blood problems (abnormal bleeding or anemia)	□	____
Blood or blood product transfusion	□	____
Chemotherapy or immunotherapy	□	____
Diabetes	□	____
Polyp or tumor removed from colon or rectum	□	____
High blood pressure	□	____
High cholesterol or triglycerides	□	____
Radiation (Cobalt or radioactive implants) therapy	□	____
Stroke or TIA	□	____
Treatment of alcohol and/or drug abuse	□	____
Tuberculosis or positive skin test for TB	□	____

MEDICATIONS

Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications. **Please use a separate piece of paper if necessary.** If you keep your list of medications and wish to provide it separately, you may bring it with you and we will make a copy for your medical chart.

Name of Medication	Dose	How Often Taken
______________________________	__________________	____
______________________________	__________________	____
______________________________	__________________	____
______________________________	__________________	____

Patient Initials/Date of Birth: ______________

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? Please list below.

Name of Medication	Describe Allergic Reaction
___________________________	__________________________________
___________________________	__________________________________
___________________________	__________________________________
___________________________	__________________________________

Have you had an allergic reaction to:

Iodine or shellfish	□ No	□ Yes
Latex, rubber or adhesive tape	□ No	□ Yes
Bee or wasp stings	□ No	□ Yes

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects?
□ No □ Yes, please explain → ____

List any food allergies ____ □ None

REVIEW OF SYSTEMS

Please circle any of the following which apply to you.

Category	Issues	No Problems
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	□
Skin	Itching, rash, mole change	□
Eyes	Vision change, cataracts, glaucoma	□
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	□
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	□
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	□
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	□
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	□
Breasts	Discharge, mass, pain, tenderness	□
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	□
Neurologic	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling, coordination, muscle strength/tone	□
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	□
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	□
Lymphatic	Enlargement, tenderness of lymph nodes	□
Hematologic	Bruising, bleeding, recurrent infections	□

Patient Initials/Date of Birth: _______________

FAMILY HISTORY

Father □ Alive (Age ___) □ Deceased (Age ___) Cause of death: ________________________________
Mother □ Alive (Age ___) □ Deceased (Age ___) Cause of death: ________________________________
Brothers # _____________ Medical Problems: ____
Sisters # _____________ Medical Problems: ____
Children # _____________ Medical Problems: ____

Please check below if any blood relative has had any of the following conditions and note which relatives affected.

□ Diabetes
□ Heart disease
□ Stroke
□ Kidney disease
□ Thyroid disease
□ Autoimmune disease
□ Easy bleeding
□ Blood clots

□ Cancer type: _________________________ Relationship to you: ____________________ Age diagnosed: ______
□ Cancer type: _________________________ Relationship to you: ____________________ Age diagnosed: ______
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□ Cancer type: _________________________ Relationship to you: ____________________ Age diagnosed: ______
□ Cancer type: _________________________ Relationship to you: ____________________ Age diagnosed: ______

Is there a history of the following cancers? Please circle:
Breast / Ovarian / Uterine / Colon / Prostate / Pancreatic / Melanoma

SOCIAL HISTORY

How many years of school have you completed? _____ Are you married? □ No □ Yes Do you live alone? □ No □ Yes
Your current employment status: □ Employed □ Retired □ Unemployed
Current or previous occupation: ____
Are you disabled? □ No □ Yes, please explain → ____
Do you have a living will or advance directive for healthcare? □ No □ Yes
If you are unable to make your own medical decisions, who will do that for you? ________________________________
Relationship to patient: ____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long (years)?	Year stopped?
Cigarettes	□ No □ Yes	□ No □ Yes			
Other Tobacco	□ No □ Yes	□ No □ Yes			
Alcohol (beer/wine)	□ No □ Yes	□ No □ Yes			
Recreational/Street Drugs	□ No □ Yes	□ No □ Yes			

Health Maintenance: Please list the date of last exam and, if abnormal, any findings if known.

Last Mammogram	______/______/______	Location:
Last Colonoscopy	______/______/______	Location:
Last Bone Density Scan	______/______/______	Location:
Last Echocardiogram	______/______/______	Location:
Shingles vaccine	______/______/______	
Influenza vaccine	______/______/______	
Pneumovax vaccine	______/______/______	