Southeast Florida Hematology-Oncology GROUP

Health Questionnaire

Date: _____

Name: _____

Date of Birth: _____

Dear Patient:

This questionnaire is designed to help your doctors know your general medical history and to save you time during your initial evaluation. Because the information is important for your healthcare, please fill it out carefully and completely. This will become part of your medical record; all information is strictly confidential. Although the questionnaire is extensive, it is not designed to focus on your current problem. Your doctor will still need to ask you other questions.

Thank you for your cooperation.

SEX:
❑ Male ❑ Female

MARITAL STATUS:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

A. GENERAL CONDITION

1. My height is _____.
2. My weight is _____.
3. My regular weight is _____.
4. My current health allows me to: (choose the single most appropriate response)
   a. Be fully active and carry on all normal activity ❑
   b. Perform activities such as light house work, office work, shopping, etc. but not to perform strenuous activities. ❑
   c. Take care of myself but not perform light work. I am out of bed more than half of the day and I get out of the house. ❑
   d. Stay pretty much at home, in bed or chair more than half of the day, but I'm able to take care of myself to some degree. ❑
   e. Be confined to bed or chair all the time. ❑
5. With regard to pain, I'm having:
   a. No pain ❑
   b. Mild pain, requiring little or no medication ❑
   c. Moderate pain, requiring regular medication ❑
   d. Severe pain, requiring regular strong pain medication such as narcotics ❑
6. My pain is: ❑ Adequately controlled ❑ Inadequately controlled

B. MEDICINES

1. Are you currently taking medications (including over-the-counter medications and/or supplements)?
   ❑ Yes ❑ No If yes, list your current medications and/or supplements:

Drug	Dose	Frequency
1.		
2.		
3.		
4.		
5.		

B. MEDICINES (CONTINUED)

1. List of current medications and/or supplements (continued):

	Drug	Dose	Frequency
6.			
7.			
8.			
9.			
10.			

2. Are you allergic to any drugs? ❑ Yes ❑ No (If no, go to C.)
   I am allergic to:

	Drug	Reaction
1.		
2.		
3.		
4.		

C. SURGERIES

1. Have you ever had surgery? ❑ Yes ❑ No
   If yes, list your operations:

	Surgery	Year (approximate)
1.		
2.		
3.		
4.		

2. Have you been hospitalized (other than current problem or surgeries as above)?

	Problem	Year (approximate)
1.		
2.		
3.		
4.		

3. Do you have any chronic medical conditions? ❑ Yes ❑ No

	Problem	Year of onset (approximate)
1.		
2.		
3.		
4.		
5.		

4. Have you had radiation? ❑ Yes ❑ No

	When	Amount
1.		
2.		
3.		

D. WOMEN ONLY:

1. I have had _____ pregnancies and _____ children.
2. I am still having menstrual periods. ❑ Yes ❑ No
   If yes:
   a. My last period was _____ (date).
   b. My periods are ❑ regular ❑ irregular.
   c. Have you had spotting or bleeding between periods? ❑ Yes ❑ No
   If no:
   a. I stopped having my menstrual periods at the age of _____.
   b. Have you had abnormal bleeding recently? ❑ Yes ❑ No
3. Have you had an abnormal pap smear? ❑ Yes ❑ No
   If yes, when? _____

E. BLOOD TRANSFUSIONS: Have you ever had blood transfusions? ❑ Yes ❑ No
If yes, did you have a reaction? ❑ Yes ❑ No
My most recent transfusion was _____ (date).

F. INJURIES: Have you ever had an accident that required medical attention or hospitalization? ❑ Yes ❑ No

Year_____ Result _____

Year_____ Result _____

G. ILLNESSES: I have had the following illnesses:

	YES	NO
Measles	❑	❑
Mumps	❑	❑
Chicken Pox	❑	❑
Shingles	❑	❑
Tuberculosis	❑	❑
Rheumatic Fever	❑	❑
Valley Fever or Coccidiodomycosis	❑	❑

H. HEALTH PROBLEMS: Have you had any of the following health problems?

Head injuries	❑	❑
Glaucoma	❑	❑
Cataracts	❑	❑
Other eye problems	❑	❑
(specify)_____		
_____		
Recurrent sinusitis	❑	❑
Nose diseases	❑	❑
Mouth diseases	❑	❑
Dental problems	❑	❑
Throat diseases	❑	❑
Thyroid disease	❑	❑
Hearing loss	❑	❑
Pneumonia	❑	❑
Pleurisy	❑	❑
Pulmonary emboli (blood clots in lung)	❑	❑

H. HEALTH PROBLEMS (CONTINUED)

	YES	NO		YES	NO
Emphysema	❑	❑	Arthritis	❑	❑
Chronic bronchitis	❑	❑	Muscle disease	❑	❑
Asthma	❑	❑	Anemia	❑	❑
Heart problems	❑	❑	Bleeding disorder	❑	❑
Angina (chest pains)	❑	❑	Stroke	❑	❑
Fluid around the heart	❑	❑	Seizure	❑	❑
Ulcer disease	❑	❑	Spinal cord problems	❑	❑
Liver disease	❑	❑	Other neurologic problem	❑	❑
Hepatitis	❑	❑	Anxiety	❑	❑
Gall stones	❑	❑	Depression	❑	❑
Bowel disease	❑	❑	Insomnia	❑	❑
Pancreatitis	❑	❑	Psychological problems	❑	❑
Kidney stones	❑	❑	Sexual problems	❑	❑
Prostate disease	❑	❑	Other problems (specify) _____		
Bladder disease	❑	❑	_____		
Venereal disease	❑	❑			

I. FAMILY HISTORY

My father is ❑ alive / ❑ dead at age _____. His health problems included _____

_____

My mother is ❑ alive / ❑ dead at age _____. Her health problems included _____

_____

I have _____ brothers and _____ sisters.

_____ of them are well. _____ have the following health problems:

_____

_____

I have _____ children.

_____ of them are well. _____ have the following health problems:

_____

_____

Other than above, there is cancer in the family as follows: _____

_____

Other diseases in the family are: _____

_____

Current living arrangements:

❑ Live alone ❑ with family members ❑ with a friend(s)

Do you have concerns you would like to discuss about:

Transportation, home care assistance, health care expenses? ❑ Yes ❑ No

Support groups, counseling? ❑ Yes ❑ No

J. SOCIAL HISTORY

I currently ❑ do not work ❑ work as _____

I previously ❑ did not work ❑ worked as _____

J. SOCIAL HISTORY (CONTINUED)

Have you been exposed to chemicals? ❑ Yes ❑ No
Specify: _____
Do you currently smoke cigarettes? ❑ Yes ❑ No
If yes, how many packs per day? _____ When did you start smoking? _____
Do you smoke cigars? ❑ Yes ❑ No If yes, how many? _____ How long? _____
Do you smoke a pipe? ❑ Yes ❑ No If yes, how many? _____ How long? _____
If you currently do not smoke, did you ever smoke? ❑ Yes ❑ No
If yes, how much did you smoke?_____ When did you quit? _____
Do you drink alcohol? ❑ Yes ❑ No If yes, please circle correct response:
1. Occasionally 2. Frequently 3. Daily How many drinks per week? _____
I ❑ Have ❑Have not had significant "recreational" drug exposure.
Have you recently traveled outside the U.S.? ❑ Yes ❑ No Where? _____

K. CURRENT SYMPTOMS

Have you had any of the following <u>in the past year</u>?

	YES	NO
Headache	❑	❑
Dizziness	❑	❑
Fainting	❑	❑
Double vision	❑	❑
Blurry vision	❑	❑
Blind spots	❑	❑
Eye pain	❑	❑
Eye swelling	❑	❑
Ear pain	❑	❑
Change in hearing	❑	❑
Ear discharge	❑	❑
Change in nose breathing or stuffiness	❑	❑
Nose bleeds	❑	❑
Mouth sores	❑	❑
Mouth pains	❑	❑
Mouth bleeding	❑	❑
Swollen lymph nodes	❑	❑
Stiff neck	❑	❑
Skin rash	❑	❑
Skin tumors	❑	❑
Other skin changes	❑	❑
Cough (dry)	❑	❑
Cough up blood	❑	❑
Cough up phlegm	❑	❑
Shortness of breath at rest	❑	❑
Shortness of breath with exercise	❑	❑
Shortness of breath at night	❑	❑
Shortness of breath while lying flat	❑	❑
Pain on deep breathing	❑	❑
Fever	❑	❑
Chills	❑	❑
Sweats	❑	❑
Chest pain	❑	❑

	YES	NO
Palpitations	❑	❑
Swollen veins	❑	❑
Swollen feet or legs	❑	❑
Nausea	❑	❑
Vomiting	❑	❑
Vomiting blood	❑	❑
Yellow eyes or skin (jaundice)	❑	❑
Belly pain	❑	❑
Belly swelling	❑	❑
Diarrhea	❑	❑
Red blood in stool	❑	❑
Purple blood in stool	❑	❑
Black tarry stools	❑	❑
White chalky stools	❑	❑
Green or yellow stools	❑	❑
Back pain	❑	❑
Difficulty urinating	❑	❑
Pain during urination	❑	❑
Frequent urination	❑	❑
Pus in urine	❑	❑
Blood in urine	❑	❑
Problems with bladder or bowel control	❑	❑
Feeling cold	❑	❑
Feeling hot	❑	❑
Seizures or fits	❑	❑
Personality change	❑	❑
Memory loss	❑	❑
Numbness or tingling	❑	❑
Loss of strength in specific areas of the body	❑	❑
Decreased coordination	❑	❑
Speech problem	❑	❑

Other problems (specify) _____
_____