PATIENT QUESTIONAIRE

PLEASE FILL OUT AS MUCH AS POSSIBLE. THIS INFORMATION IS IMPORTANT TO PLANNING YOUR CARE.

NAME_____ AGE_____ DATE_____

MAIDEN NAME_____ BIRTHPLACE_____

PRIMARY CARE PHYSICIAN_____

OTHER PHYSICIANS (address if out of area) _____

_____

_____

PLEASE DESCRIBE WHAT BROUGHT YOU HERE TODAY. INCLUDE SYMPTOMS/TESTS/SURGERIES/PHYSICIANS VISITS

_____	**PHYSICIAN NOTES**

LIST ANY CURRENT OR PAST MEDICAL PROBLEMS (eg diabetes, high blood pressure)

_____	**PHYSICIAN NOTES**

Name_____Date_____Page 2

LIST ANY SURGERIES / HOSPITALIZATION

DATE	SURGERY/HOSPITALIZATION	PHYSICIAN	**PHYSICIAN NOTES**

PREVIOUS RADIATION (at any facility)

_____

ALLERGIES_____

MEDICATIONS (INCLUDE ALL HERBS / VITAMINS / SUPPLEMENTS)

Name of Medication	Physician who Prescribed	How often is the Medication taken

LIVING WILL / ADVANCED DIRECTIVE (copy for chart) Yes___ No___
HEALTH CARE SURROGATE (representative)_____

CHECK THE FOLLOWING THAT APPLY
Married____ Widow(ed)____ Single____ Separated____ Divorced____
Cigarette / Cigar / Pipe / Chew (circle all that apply) # of Years____ Amount per day____
Alcohol Use___ Amount per Day____ Caffeine____ Amount per day___
OCCUPATION_____
Employed: Full time_____ Part time_____ Retired_____ Unemployed____ Disabled____
Family History of Cancer_____

_____

ANY OTHER IMPORTANT INFORMATION LISTED OR CONCERNS THAT YOU HAVE (Please Describe)

_____

_____

ANY IMPLANTED DEVICES (eg. Pacemaker, etc…)_____

CHECK ALL THAT APPLY (Review of systems)

	YES	NO	COMMENTS
PAIN/LOCATION RELIEF MEASURES			
WEIGHT LOSS (AMOUNT)			
CHEMICAL EXPOSURE (eg. asbestos etc…)			
NIGHT SWEATS HOT FLASHES			
FATIGUE SLEEP HABITS CHANGED			
HEADACHES			
VISION/HEARING CHANGES			
SEIZURES			
PARALYSIS			
FEVERS			
DIZZINESS			
CHEST PAIN			
PALPITATIONS			
COUGH			
SHORT OF BREATH			
COUGH UP BLOOD			
SWELLING OF ANKLES OR FEET			
NAUSEA/VOMITING			
TROULBE SWALLOWING			
CHANGE IN URINATION			
BLOOD IN URINE			
FREQUECY/UNCONTROLLED URINATION			
URINATE AT NIGHT			
SEXUALLY ACTIVE			
CHANGE IN SEXUAL FUNCTION			
DIARRHEA			
BLACK STOOLS			
BLOOD IN STOOL			
SKIN PROBLEMS			
BLEEDING/BRUISING			

FEMALE PATIENTS

Are you pregnant? Yes__ No__ # of Pregnancies___ # of Births__ Age of first Preg.___
Breast Fed children? Yes___ No____ Age started periods____ Light__ Normal__ Heavy__
Menopause Age__ Vaginal Bleeding/Discharge_____
Hormonal Therapy Yes__ No__ Type_____