

General and Surgical Oncology Specialists of Central PA

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please complete every section. Do not leave any blanks.

NAME: _____ DOB: ___/___/___ AGE: _____ APPT DATE: ___/___/___

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

FAMILY DR: _____ REQUESTING DR: _____

OTHER TREATING PHYSICIANS: _____

ALLERGIC TO: (medications, environmental, food)	TYPE OF REACTION:

PAST MEDICAL HISTORY: (Please check all that apply to you now or in the past)		
<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Aneurysms <input type="checkbox"/> Blood Clots (DVT) <input type="checkbox"/> Bruising/Bleeding Easily <input type="checkbox"/> Chest pain <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Heart Attack/Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Internal Pacemaker <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Palpitations <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Rheumatic Fever 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> COPD <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Pneumonia <input type="checkbox"/> Reactive Airway <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Tuberculosis 	<p>Oncologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer (type) _____ _____ (location) _____ _____ <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid
<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's <input type="checkbox"/> Dehydration <input type="checkbox"/> Diarrhea <input type="checkbox"/> GI Bleed/Ulcer Disease <input type="checkbox"/> Heartburn <input type="checkbox"/> Hepatitis (A, B, C) <input type="checkbox"/> Hiatal hernia/Reflux <input type="checkbox"/> IBS (irritable bowel) <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver Disease <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Ulcerative Colitis 	<p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dialysis <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Urinary tract Infection <input type="checkbox"/> Uterine Prolapse <input type="checkbox"/> STD <p>Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Antibiotic Resistance <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Immunosuppression <input type="checkbox"/> MRSA 	<p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke/Mini Stroke (TIA) <p>Behavior/Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Panic Attack <input type="checkbox"/> Schizophrenia
<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal Walking <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Injury/Pain <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Fracture <input type="checkbox"/> Lupus <input type="checkbox"/> Spina Bifida 	<p>Hematologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell Anemia 	<p>Other (Please list any other medical problems)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Please list your medications below: (include aspirin, herbals, eye drops and all over the counter medication)

Medication Name	Dose (how many milligrams)	Frequency (How many times per day)

Please list any previous surgery:

Date	Type of Surgery	Hospital

Social History:

Do you smoke Cigarettes? ___Yes ___No if yes, how many packs per day: _____, how many years: _____

___Quit smoking _____years ago ___Never smoked

Do you use any other Tobacco products: ___Cigars ___Pipe Tobacco ___Chew Tobacco

Do you drink Alcohol? ___Yes ___No If yes, what type: _____, How Often: _____

Do you use any recreational or street drugs? ___Yes ___No If yes, what type: _____, How often: _____

Family Medical History:

___Cancer ___COPD or Asthma ___Heart Disease ___High Blood Pressure or Stroke ___Kidney Disease

___ Blood clots ___ Diabetes ___Other Illness _____

Review of Systems: (Please mark if you are CURRENTLY experience these symptoms)

<ul style="list-style-type: none"> <input type="checkbox"/> Double/Blurred Vision <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Chest Pain/Pressure <input type="checkbox"/> Cough <input type="checkbox"/> Dizziness <input type="checkbox"/> Swelling of Feet <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Nausea/Vomiting 	<ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Wheezing <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Change in BMS <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Indigestion <input type="checkbox"/> Jaundice <input type="checkbox"/> Abdominal Pain 	<ul style="list-style-type: none"> <input type="checkbox"/> Vomited blood <input type="checkbox"/> Decreased Urine <input type="checkbox"/> Pain while urinating <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Fainting <input type="checkbox"/> Headache <input type="checkbox"/> Depression
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The above information is true and correct to the best of my knowledge.

Patient Signature (Parent or Guardian for Minor) and Date

Physician Signature and Date