

DALLAS ONCOLOGY CONSULTANTS, P. A.

HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

What is your principal reason for seeing the doctor? _____

Duration of this problem? _____

REVIEW BY SYSTEMS

GENERAL SYMPTOMS

- Do you feel weak or tired?..... Yes () No ()
- Have you lost your appetite? Yes () No ()
- Have you lost weight? Yes () No ()
- Amount _____
- Do you actually run fever? Yes () No ()
- Have you noticed any swelling anywhere?..... Yes () No ()
- If yes, where? _____
- Do your feet or ankles swell? Yes () No ()

HEAD, EYES, EARS, NOSE, THROAT

- Do you have headaches? Yes () No ()
- Do you have "sinus trouble"? Yes () No ()
- Have you been hoarse lately? Yes () No ()
- Do you have trouble with vision? Yes () No ()
- Do you have trouble hearing? Yes () No ()

CHEST

- Do you have a cough? Yes () No ()
- Have you ever coughed up any blood? Yes () No ()
- Are you short of breath? Yes () No ()
- Does your chest wall hurt? Yes () No ()

DIGESTIVE SYSTEM

- Do you have trouble swallowing? Yes () No ()
- Do you ever vomit? If yes, when? Yes () No ()
- If yes, when? _____
- Do you have pain in your abdomen? Yes () No ()
- Are you often constipated? Yes () No ()
- Do you take laxatives or enemas often? Yes () No ()
- Do you have loose bowels or diarrhea? Yes () No ()
- Do you ever pass blood from the rectum? Yes () No ()
- Do you ever have black or "tarry" stools? Yes () No ()
- Have you ever had a flexible sigmoidoscopy or a colonoscopy?..... Yes () No ()
- If yes, when? _____

GENITO/URINARY

Do you have trouble passing urine? Yes () No ()
Do you have burning or pain when urinating? Yes () No ()
Have you recently had an infection, blood or pus, in your urine? Yes () No ()
For males over 50, have you had a prostate exam? Yes () No ()

BONES, JOINTS, MUSCLES

Do you have any back pain? Yes () No ()
Do you have joint pain? Yes () No ()

NERVOUS SYSTEM

Do you have weakness in your arms or legs? Yes () No ()
Do you have numbness in your hands or feet? Yes () No ()

MENSTRUAL HISTORY (for women only)

How many times have you been pregnant? _____
Have you ever had a miscarriage? Yes () No ()
When was your last menstrual period? _____
Are your menstrual periods irregular? Yes () No ()
Do you menstruate too heavily? Yes () No ()
If you have stopped menstruating, at what age? _____
Do you have any menopausal symptoms? Yes () No ()
Are you on birth control pills or hormone replacement therapy? Yes () No ()
Have you had a vaginal examination and "PAP" smear in the last year? Yes () No ()
Have you ever had a breast x-ray? (mammogram) Yes () No ()

PAST HISTORY

List operations, if any: _____ Date _____
1. _____
2. _____
3. _____
4. _____

Have you had any previous blood transfusions? Yes () No ()
If yes, when? _____

PAST MEDICAL PROBLEMS:

Bronchial or lung trouble? Yes () No ()	Stroke or Convulsions? Yes () No ()
Tumor, growth or cancer? Yes () No ()	Gall bladder trouble? Yes () No ()
Heart trouble? Yes () No ()	Ulcer? Yes () No ()
High blood pressure? Yes () No ()	Jaundice or Hepatitis? Yes () No ()
Diabetes? Yes () No ()	Prostate trouble? Yes () No ()
Others (list): _____	Kidney/Bladder trouble? Yes () No ()

FAMILY HISTORY

Father: Living? _____ Age? _____ Health: _____
 Dead? _____ At Age? _____ Cause of Death? _____
 Mother: Living? _____ Age? _____ Health: _____
 Dead? _____ At Age? _____ Cause of Death? _____
 Brothers: No. Living? _____ Health: _____
 No. Dead? _____ Cause of Death? _____
 Sisters: No. Living? _____ Health: _____
 No. Dead? _____ Cause of Death? _____
 Are you married now? Yes () No ()
 Children? Number? _____ Ages? _____ Health: _____
 Any dead? _____ Causes? _____
 Any history of cancer in your family? _____

PERSONAL HISTORY

Do you smoke? Yes () No ()
 Or have you ever smoked? Yes () No ()
 Number per day: Cigarettes? _____ Cigars? _____ Pipe? _____
 Drink coffee? Yes () No ()
 Number cups per day? _____
 Drink beer, wine, liquor? Yes () No ()
 Number drinks per day? _____ Week? _____
 Has drinking ever been a problem? Yes () No ()
 Have you ever had a drug problem or are you using drugs now? Yes () No ()
 Occupation: _____

MEDICATIONS & ALLERGIES

Are you taking any medicines? Yes () No ()
 List: _____

 Do you take any natural/herbal products, over-the-counter medications, or vitamins? Yes () No ()
 If yes, list: _____

 Are there any medications or drugs to which you are allergic, or have bad effects on you? Yes () No ()
 List: _____
