THE UNIVERSITY OF KANSAS
CANCER CENTER

NCI Cancer Center
A Cancer Center Designated by the National Cancer Institute

MEDICAL HISTORY QUESTIONNAIRE

Welcome! *Please complete the following health history before you see your physician.*
For your convenience this form is also available online at kucancercenter.org.
Please print a copy for your records, and bring to your first appointment.

Name: _____

Birthdate: _____ Date: _____

REASON FOR VISIT: (current symptoms) _____

_____

_____

HERBAL MEDICATIONS OR SUPPLEMENTS: Please include all drugs and supplements you are taking.

Name	Dose & Frequency	Name	Dose & Frequency
1) _____	_____	5) _____	_____
2) _____	_____	6) _____	_____
3) _____	_____	7) _____	_____
4) _____	_____	8) _____	_____

MEDICATIONS: Include prescription and over-the-counter medications; feel free to attached a printed or typed list of medications instead.

Name	Dose & Frequency	Name	Dose & Frequency
1) _____	_____	7) _____	_____
2) _____	_____	8) _____	_____
3) _____	_____	9) _____	_____
4) _____	_____	10) _____	_____
5) _____	_____	11) _____	_____
6) _____	_____	12) _____	_____

PREFERRED PHARMACY:

Name	Address	Telephone
_____	_____	_____

HISTORY:

Do you have Living Will or Advanced Directive? ◯ Yes ◯ No

CANCER MEDICAL HISTORY:

- ☐ Anal Cancer
- ☐ Bladder Cancer
- ☐ Brain Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ Esophageal Cancer
- ☐ Gastric Cancer
- ☐ Hepatobiliary Cancer
- ☐ Hodgkin's Lymphoma
- ☐ Kidney Cancer
- ☐ Larynx Cancer
- ☐ Leukemia
- ☐ Mesothelioma
- ☐ Multiple Myeloma
- ☐ Myelodysplastic Syndrome
- ☐ Neuroendocrine Cancer
- ☐ Non-Hodgkins Lymphoma
- ☐ Non-Small Cell Lung Cancer
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Renal Failure
- ☐ Sarcoma
- ☐ Skin Cancer
- ☐ Small cell lung cancer
- ☐ Stomach Cancer
- ☐ Testicular Cancer
- ☐ Thyroid Cancer
- ☐ Tongue Cancer
- ☐ Unknown Primary Cancer
- ☐ Uterine Cancer

MEDICAL HISTORY:

- ☐ Acute infection
- ☐ Arthritis
- ☐ Back pain
- ☐ Birth defect
- ☐ Bleeding tendency
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Hearing problems
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Home oxygen use
- ☐ Osteoporosis
- ☐ Seizure disorder
- ☐ Sexual disease
- ☐ Stomach problem
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcer
- ☐ Vision problems

OTHER MEDICAL HISTORY:

_____

_____

_____

WOMEN ONLY - OB/Gyn History:

LMP: _____ Having Periods?: ◯ Yes ◯ No

Age of first menstrual cycle: _____ Age of first live birth: _____

Number of live births: _____ Number of pregnancies: _____

Did you Breastfeed?: ◯ Yes ◯ No If yes, for how long?: _____

CANCER SURGICAL HISTORY:

Surgery Type

- ☐ Adrenalectomy (adrenal)
- ☐ Cytoreductive Surgery (chemo during surgery)
- ☐ Right Colectomy (colon)
- ☐ Left Colectomy (colon)
- ☐ Esophagectomy (esophagus)
- ☐ Hepatico-Jejunostomy (liver/intestine)
- ☐ Lymph Node Biopsy
- ☐ Lymphadectomy (lymph nodes)
- ☐ Nephrectomy (kidney)
- ☐ Parathyroid
- ☐ Port Placement
- ☐ Prostatectomy (prostate)
- ☐ Sigmoidectomy (partial colon)
- ☐ Thyroidectomy (thyroid)
- ☐ Whipple (pancreas)

SURGICAL/PROCEDURAL HISTORY:

Surgery Type

- ☐ Appendectomy (appendix)
- ☐ Cardiac Catheterization (heart cath)
- ☐ Hysterectomy (uterus)
- ☐ Colonoscopy
- ☐ Cholecystectomy (gall bladder)

OTHER SURGICAL HISTORY:

_____

_____

_____

_____

ALLERGIES: Please list any allergies to medications or foods. Examples of reactions: rash or hives, trouble breathing, nausea.

	Name	**Reaction**
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

MAINTENANCE:

DATE OF LAST TETANUS SHOT_____ LAST FLU SHOT:_____

LAST PNEUMONIA SHOT: _____

SUBSTANCE HISTORY:

Tobacco Use:

- ☐ Current Every Day Smoker
- ☐ Current Some Days Smoker
- ☐ Former Smoker – **Quit Date:** _____
- ☐ Heavy Tobacco Smoker
- ☐ Light Tobacco Smoker
- ☐ Never Smoked
- ☐ Passive, Smoke Exposure – Never Smoked
- ☐ Smoker, Current Status Unknown

Tobacco Type: ☐ Cigarettes ☐ Pipe ☐ Cigars

Packs/Day: ☐ .25 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3

Years: ☐ .5 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 10 ☐ 15 ☐ ____ years

Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown

Types: ☐ Snuff ☐ Chew

Quit Date: _____

Ready To Quit: ○ Yes ○ No

Alcohol Use: ○ Yes ○ No

Drinks/Week: _____ Glasses of Wine _____ Cans of Beer

_____ Shots of liquor _____ Drinks containing 0.5 oz of alcohol

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Drug Use: ○ Yes ○ No **Per Week:**_____

Type: ☐ Marijuana ☐ Methamphetamines ☐ Cocaine ☐ IV ☐ Heroin ☐ PCP ☐ Other: _____

PAST HOSPITALIZATIONS:

_____

_____

_____

REFERRING PROVIDER:

Primary Care Physician: _____

Address: _____

Phone Number: _____

Referring Provider: _____

Address: _____

Phone Number: _____

FAMILY HISTORY:

Please indicate the age of diagnosis (if known) **AND** if the family member is A = Alive D = Deceased	Mother	Father	Sister	Brother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Cancer – Breast													
Cancer – Colon													
Cancer – Lung													
Cancer – Ovarian													
Cancer – Prostate													
Cancer – Thyroid													
Cancer – Uterine													
Cancer													
Diabetes													
Heart Disease													
Hypertension													
Asthma													
High Cholesterol													
Arthritis – Rheumatoid													
Arthritis – Osteoporosis													
Stroke													
Thyroid Disease													
Seizures													
Migraines													
Rashes/Skin Problems													
Depression													
None Reported													
Unknown to Patient													
Coronary Artery Disease													
Hyperlipidemia													

FAMILY HISTORY UNKNOWN ☐

Please indicate if you are experiencing any of the symptoms below.

General	Eyes	GU	Neurological
☐ Activity change	☐ Eye discharge	☐ Difficulty urinating	☐ Dizziness
☐ Appetite change	☐ Eye itching	☐ Painful urination - Dysuria	☐ Facial asymmetry
☐ Chills	☐ Eye pain	☐ Incontinence - Enuresis	☐ Headaches
☐ Sweating - Diaphoresis	☐ Eye redness	☐ Flank pain	☐ Light-headedness
☐ Always tired - Fatigue	☐ Light sensitivity - Photophobia	☐ Frequency	☐ Numbness
☐ Fever	☐ Visual disturbance	☐ Genital sore	☐ Seizures
☐ Unexpected weight change	**Respiratory**	☐ Blood in urine - Hematuria	☐ Speech difficulty
HENT	☐ Sleep disturbance - Apnea	☐ Urgency	☐ Fainting - Syncope
☐ Congestion	☐ Chest tightness	☐ Urine decreased	☐ Tremors
☐ Dental problem	☐ Choking	**GU (male only)**	☐ Weakness
☐ Drooling	☐ Cough	☐ Penile discharge	**Hematologic**
☐ Ear discharge	☐ Shortness of breath	☐ Scrotal swelling	☐ Enlarged lymph node - Adenopathy
☐ Ear pain	☐ Inhale wheeze (Stridor)	☐ Testicular pain	☐ Bruises/bleeds easily
☐ Facial swelling	☐ Wheezing	**GU (female only)**	**Psychiatric**
☐ Mouth sores	**Cardiovascular**	☐ Menstrual problem	☐ Agitation
☐ Nosebleeds	☐ Chest pain	☐ Pelvic pain	☐ Behavior problem
☐ Postnasal drip	☐ Leg swelling	☐ Vaginal bleeding	☐ Confusion
☐ Runny nose - Rhinorrhea	☐ Rapid heartbeat - Palpitations	☐ Vaginal discharge	☐ Decreased concentration
☐ Sinus Pressure	**GI (Gastrointestinal)**	☐ Vaginal pain	☐ Dysphoric mood
☐ Sneezing	☐ Abdominal distention	**MS (joint/bone)**	☐ Hallucinations
☐ Sore throat	☐ Abdominal pain	☐ Joint pain - Arthralgia	☐ Hyperactive
☐ Ringing in ear - Tinnitus	☐ Anal bleeding	☐ Back pain	☐ Nervous/anxious
☐ Trouble swallowing	☐ Blood in stool	☐ Gait problem	☐ Self-injury
☐ Voice change	☐ Constipation	☐ Joint swelling	☐ Sleep disturbance
	☐ Diarrhea	☐ Muscle pain (Myalgia)	☐ Suicidal ideas
	☐ Nausea	☐ Neck pain	**Other**
	☐ Rectal pain	☐ Neck stiffness	
	☐ Vomiting	**Skin**	
		☐ Color change	
		☐ Pale skin - Pallor	
		☐ Rash	
		☐ Wound	