THE UNIVERSITY OF KANSAS
CANCER CENTER

NCI Comprehensive 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.*

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 attach 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
- ☐ Hodgkin lymphoma
- ☐ Kidney cancer
- ☐ Larynx cancer
- ☐ Leukemia
- ☐ Mesothelioma
- ☐ Multiple myeloma
- ☐ Myelodysplastic syndrome
- ☐ Neuroendocrine cancer
- ☐ Non-Hodgkin 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
- ☐ Prior radiation therapy

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 problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcer
- ☐ Vision problems

OTHER MEDICAL HISTORY:

_____

_____

_____

OBGYN HISTORY (females only)

Last menstrual period: _____ Having periods?: ☐ Yes ☐ No

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

Number of live births: _____ Number of pregnancies: _____

CANCER SURGICAL HISTORY:

Surgery Type

- ☐ Adrenalectomy (adrenal)
- ☐ Craniotomy (brain)
- ☐ Cystectomy (bladder)
- ☐ Cytoreductive surgery (chemo during surgery)
- ☐ Right colectomy (colon)
- ☐ Left colectomy (colon)
- ☐ Esophagectomy (esophagus)
- ☐ Gastrectomy (stomach)
- ☐ Hepaticojejunostomy (liver/intestine)
- ☐ Lung lobectomy
- ☐ Lymph node biopsy
- ☐ Lymph node dissection
- ☐ Lymphadectomy (lymph nodes)
- ☐ Mastectomy (breast)
- ☐ Nephrectomy (kidney)
- ☐ Oophorectomy (ovary)
- ☐ Orchiectomy (testicle)
- ☐ Parathyroid
- ☐ Pneumonectomy (lung)
- ☐ Port placement
- ☐ Prostatectomy (prostate)
- ☐ Sigmoidectomy (partial colon)
- ☐ Skin biopsy
- ☐ Skin resection
- ☐ Thymectomy (thymus)
- ☐ 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 PNEUMONIA SHOT: _____

LAST FLU 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 ☐ No

Types ☐ Snuff ☐ Chew

Quit date: _____

Ready to quit: ◯ Yes ◯

Alcohol use: ◯ Yes ◯ Not currently ◯ Never

Drinks/week: _____ Glasses of wine _____ Cans of beer

_____ Shots of liquor _____ Drinks containing 0.5 oz of alcohol

Drug Use: ◯ Yes ◯ Not currently ◯ Never **Per week:**_____

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

PAST HOSPITALIZATIONS:

_____

_____

_____

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 problems	☐ 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 problems	☐ Agitation
☐ Nosebleeds	☐ Chest pain	☐ Pelvic pain	☐ Behavior problems
☐ 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 problems	☐ 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	