Southwest Oncology CENTERS

PATIENT HEALTH QUESTIONNAIRE

(PLEASE PRINT YOUR ANSWERS)

Name:_____ Date: _____

SS#: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Current Medications: _____

_____

_____

List all Medications You Cannot Take or are Allergic to: _____

_____

_____

Do You Take Aspirin, any Aspirin Containing Medications, or Non-Steroidal Anti-Flammatory Drugs? ☐ YES ☐ NO

MEDICAL HISTORY:

Serious injuries / Illnesses / Medical Problems (cancer): _____

_____

_____

Previous Hospitalizations and Surgeries: _____

_____

_____

Previous Radiation Therapy (Location, Radiation Oncologist, Diagnosis, Site Treated, Date): _____

_____

_____

Are you experiencing any: (please check all that apply):

☐ Fever	☐ Double Vision	☐ Weight Loss	☐ Chest Pain	☐ Cough
☐ Chills	☐ Lungs	☐ Diabetes	☐ Shortness of Breath	☐ Night Sweats
☐ Fatigue	☐ Lumps/Bumps	☐ Bone Pain		

Please Explain: _____

_____

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PATIENT HEALTH QUESTIONNAIRE (Cont.)

Have you ever had problems or been diagnosed with:

☐ Arthritis	☐ Cataract	☐ Glaucoma	☐ Skin Cancer	☐ High Blood Pressure
☐ High Cholesterol	☐ Heart Problems	☐ Pneumonia	☐ Bronchitis	☐ Asthma
☐ Abnormal chest x-ray	☐ Diabetes	☐ Thyroid Problems	☐ Diverticulosis	☐ Ulcer
☐ Constipation	☐ Loose Stool	☐ Seizure	☐ Stroke	☐ Depression

Please Explain: _____

_____

FAMILY MEDICAL HISTORY – DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS HAD: (indicate relationship)

Arthritis	_____	Heart Disease	_____
Asthma / Allergies	_____	High Blood Pressure	_____
Bleeding	_____	Kidney Stones	_____
Cancer	_____	Kidney Failure	_____
Diabetes	_____	Mental Illness	_____
Genetic Disorder	_____	Reaction to Anesthesia	_____
Stroke	_____	Tuberculosis	_____

PATIENT SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: _____ Ethnicity: _____ Race: _____

Religion: _____

Current Occupation: _____

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Caffeine (cups per day): Coffee_____ Soda_____ Tea_____

Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Current (packs per day _____)

Exercise: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Type of Exercise:_____