

**CANCER CENTER**

4501 X STREET  
Sacramento, CA 95817  
(916) 734-5959 (Appt. Scheduling)

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT.

**PATIENT MEDICAL HISTORY QUESTIONNAIRE**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

I. A. What present medical problem causes you to seek medical help?

\_\_\_\_\_  
\_\_\_\_\_

B. Describe when it started and how it started, symptoms, medications taken and results.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Who are the doctors involved in your medical care?

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**II. PAST HISTORY:** (check diseases you have had)

A. Infectious Diseases

- Measles
- Mumps
- Chicken pox
- Meningitis
- Syphilis
- Tuberculosis
- Scarlet Fever
- Small pox
- Whooping Cough
- Diphtheria
- Typhoid Fever
- Gonorrhea
- Fungal Disease
- Rheumatic Fever
- St. Vitus Dance
- Pneumonia
- Infectious Mononucleosis
- Infectious Hepatitis
- Amoeba

B. Operations/Medical Illnesses: (list) Year

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Have you ever had a problem with general anesthesia?

\_\_\_\_\_  
\_\_\_\_\_

D. Broken Bones/Accidents or Trauma:

\_\_\_\_\_  
\_\_\_\_\_

E. Prior history of cancer? Yes  No

\_\_\_\_\_

F. Prior radiation therapy? Yes  No

G. Immunizations Year

- |   |  |
|---|--|
| <input type="checkbox"/> Diphtheria _____ | <input type="checkbox"/> Polio _____     |
| <input type="checkbox"/> Pertussis _____  | <input type="checkbox"/> Measles _____   |
| <input type="checkbox"/> Tetanus _____    | <input type="checkbox"/> Mumps _____     |
| <input type="checkbox"/> Typhoid _____    | <input type="checkbox"/> Small pox _____ |
| <input type="checkbox"/> Influenza _____  |  |

H. Do you have, or have you had any diseases not mentioned above?

\_\_\_\_\_  
\_\_\_\_\_

**III. SYSTEM REVIEW:**

A. GENERAL HEALTH: Good  Fair  Bad

Easily Fatigued: Yes  No

Night Sweats: Yes  No

Weight: Loss - how much \_\_\_\_\_

Gain - how much \_\_\_\_\_

Stable \_\_\_\_\_

Appetite: Good  Fair  Poor

Sleep: Good  Fair  Poor

Fevers: Yes  No

B. GASTROINTESTINAL TRACT: (check if "yes")

Have you ever been bothered with:

- 1. Sore, painful tongue
- 2. Tongue enlargement
- 3. Difficulty Swallowing



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**B. GASTROINTESTINAL TRACT:** (check if "yes") Cont'd

- 4. Pain in abdomen or abdominal cramps
- 5. Yellow jaundice
- 6. Nausea
- 7. Vomiting and/or blood vomitus
- 8. Diarrhea
- 9. Constipation
- 10. Bloody, tarry or clay colored BM's
- 11. Excessive belching or gas
- 12. Intolerance to foods
- 13. Hemorrhoids
- 14. Pressure sensation in chest or upper abdomen
- 15. Stomach ulcers
- 16. Gall bladder disease

**C. HEMATOLOGIC SYSTEM:** (check if "yes")

- Anemia
- Bleeding tendencies
- Blood disease
- Blood transfusions
- Date: \_\_\_\_\_
- Any allergic reactions? Yes  No

**D. CARDIOVASCULAR SYSTEM:** (check if "yes")

Have you had or do you have:

- 1. Chest pain with/without exercise or excitement
- 2. Shortness of breath with or without exercise
- 3. Cough and/or sputum
- 4. Wheezing in chest
- 5. Can't lie flat to sleep
- 6. Wake up at night short of breath
- 7. Rapid and/or irregular heart beat
- 8. Asthma or hay fever
- 9. Heart attack
- 10. High or low blood pressure
- 11. Swelling in legs or feet, dropsy

**E. GENITO URINARY SYSTEM:** (check if "yes")

- 1. Frequency
- 2. Albumin or sugar in urine
- 3. Urgency
- 4. Trouble starting or stopping stream
- 5. Incontinence
- 6. Getting up at night to urinate
- 7. Painful urination
- 8. Venereal disease or bad blood
- 9. Stricture
- 10. Bleeding after intercourse
- 11. Loss of interest in sex
- 12. Kidney or bladder infection
- 13. Kidney or bladder stones

**F. NEUROMUSCULAR MOTOR SYSTEM:** (check if "yes")

- Muscle Paralysis  Convulsions
- Weakness  Unconsciousness
- Painful/Swollen Joints  Hearing Loss
- Double/Impaired Vision  Fainting Spells
- Headaches  Difficulty Keeping Equilibrium
- Ringing in Ears  Shooting Pains in Legs
- Dizziness  Numbness or Tingling of Hands and Feet
- Nervous Breakdown
- Weak Back

**G. FEMALE ONLY:**

- 1. When did you first menstruate? \_\_\_\_\_
- 2. When did you stop menstruating? \_\_\_\_\_
- 3. Cycle -- Every \_\_\_\_\_ days. Last MP \_\_\_\_\_
- 4. Excessive or scanty bleeding? \_\_\_\_\_
- 5. Number of pregnancies\_\_\_\_ Number of children\_\_\_\_  
Number of miscarriages\_\_\_\_ Number of abortions\_\_\_\_  
Weight of largest baby at birth \_\_\_\_\_
- 6. Have you ever been treated for an abnormal pap smear?
- 7. Date of last pap smear \_\_\_\_\_
- 8. Have you ever had a pelvic infection?
- 9. Have you ever had a venereal disease?
- 10. Do you practice monthly self-breast exams?
- 11. Date of last mammograms \_\_\_\_\_

**IV. FAMILY HISTORY:**

- Mother  Living  Dead Age \_\_\_\_\_  
State of health/Cause of death \_\_\_\_\_
- Father  Living  Dead Age \_\_\_\_\_  
State of health/Cause of death \_\_\_\_\_
- Brothers No. Living \_\_\_\_\_ No. Dead \_\_\_\_\_ Age \_\_\_\_\_  
State of health/Cause of death \_\_\_\_\_
- Sisters No. Living \_\_\_\_\_ No. Dead \_\_\_\_\_ Age \_\_\_\_\_  
State of health/Cause of death \_\_\_\_\_

Is there a history of the following diseases in your family?  
Please check.

- Diabetes  Kidney or Bright's Disease
- High Blood Pressure  Rheumatic Fever
- Strokes  Bleeding Tendency
- Tuberculosis  Arthritis and/or Gout
- Heart Attacks  Asthma
- Epilepsy  Dropsy
- Alcoholism  Nervous Breakdowns
- Cancer

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**PATIENT QUESTIONNAIRE**

**V. PERSONAL HISTORY**

Birthdate: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Education (highest): \_\_\_\_\_

Occupation: \_\_\_\_\_

Have you ever lived outside the United States?  Yes  No

If so, where and for how long? \_\_\_\_\_

Military Service: When \_\_\_\_\_

What did you do? \_\_\_\_\_

Highest Rank attained \_\_\_\_\_

Married \_\_\_\_\_ years Age of Spouse \_\_\_\_\_ Health of Spouse \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages \_\_\_\_\_ Sexes \_\_\_\_\_

Medications:

Medications taken on a regular basis including aspirin and aspirin-containing products \_\_\_\_\_

Medications you are allergic to \_\_\_\_\_

**VI. SOCIAL HABITS**

Smokes \_\_\_\_\_ cigarettes/day

\_\_\_\_\_ cigars/day

\_\_\_\_\_ lbs. chewing tobacco/week

Alcohol intake \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ On Occasion

**VII. PERSONAL LIFESTYLE**

Do you worry a great deal?  Yes  No

Fearful?  Yes  No

Like yourself?  Yes  No

Like to be around others?  Yes  No

Get depressed?  Yes  No

Like your work?  Yes  No

Have hobbies?  Yes  No

Do you have any spiritual support?  Yes  No

Have pets?  Yes  No

Have good communications with your Spouse?  Yes  No  Sometimes

