Cancer Center of Kansas

cancercenterofkansas.com

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date:_____ Religion: _____

Marital Status: ☐ Married / ☐ Single / ☐ Divorced / ☐ Widowed / ☐ Partnered Age: _____

Occupation: _____ Date of Birth:_____

SURGICAL HISTORY (Please check any surgeries YOU have had):

☐ Tonsillectomy	☐ Vasectomy	☐ Cataracts	☐ Prostate Surgery
☐ Appendectomy	☐ Hysterectomy	☐ Gall Bladder	☐ Hip Replacement
☐ Cardiac Bypass	☐ Tubal Ligation	☐ Hernia	☐ Knee Replacement
☐ Cesarean Section	☐ Other (Specify):		

HOSPITALIZATION HISTORY (other than for surgery) _____

PAST ILLNESSES (Circle any illnesses YOU have or have had)

Diabetes	Hearing Loss	Rheumatic Fever	HIV/AIDS	Thyroid Disease
Hay Fever	Anemia	Urine Infections	Depression	Asthma
Bleeding Problems	Kidney disease/stones	Head Trauma	Bronchitis/Emphysema	Blood clots in lungs/legs
Arthritis	Stroke	Tuberculosis	High cholesterol	Chicken Pox
Seizures	High Blood Pressure	Ulcers	Cataracts	Angina/chest pain
Irritable Bowel Syndrome	Glaucoma	Heart Disease	Hepatitis/Jaundice	Skin Conditions
Irregular Heart Rhythm	Sexually Transmitted Disease		Cancer (Specify): _____	

Other: _____

FAMILY HEALTH HISTORY

Relative		Age	List any Diseases	If Deceased, Cause of Death
Father				
Mother				
Father's Parents	**Mother**			
	Father			
Mother's Parents	**Mother**			
	Father			
Brothers				
Sisters				
Children:				
First Cousins:				

CONTINUED ON BACK

Name: _____

YOUR CANCER HISTORY

Type of Cancer: _____ Date of Diagnosis: _____

Have you had treatment for this diagnosis? _____ ☐ Yes / ☐ No

If yes, give details: _____

If you have had surgery for your cancer, where was it done? _____

RECENT DIAGNOSTIC TESTS

When was your last chest x-ray? _____ ☐ Never had one

When did you last have any lab testing? _____ ☐ Never had lab

When was your last colonoscopy? _____ ☐ Never had one

When was your last EGD? _____ ☐ Never had one

WOMEN'S HISTORY

Age at time of first menstrual period: _____ Date of last menstrual period: _____

Age at menopause: _____ ☐ Natural / ☐ Hysterectomy

Have you ever taken hormones or birth control pills? _____ ☐ Yes / ☐ No

Name or type of hormones or birth control pills: _____

Approximate date stopped: _____ Age at first pregnancy: _____

When was your last pap smear/pelvic exam? _____ ☐ Not had one

When was your last dexa scan (bone density scan)? _____ ☐ Not had one

When was your last mammogram? _____ ☐ Not had one

PERSONAL HISTORY

Do you drink alcoholic beverages? ☐ Yes / ☐ No

If yes, how many glasses of ☐ beer / ☐ wine / ☐ hard liquor per day? _____

Have you recently ☐ gained / or ☐ lost weight? _____ ☐ Yes / ☐ No

If yes, approximately how much weight gained _____ or lost _____?

Over what period of time? _____ weeks / _____months

Have you ever had a blood transfusion? ☐ Yes / ☐ No If yes, what year? _____

Did you have a reaction? ☐ Yes / ☐ No

ADVANCE DIRECTIVES

Do you have a Living Will? _____ ☐ Yes / ☐ No

Do you have a Power of Attorney for Health Care Decisions? _____ ☐ Yes / ☐ No

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Patient Name: _____

Email Address				Date:
Race (check one)	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Unknown ☐ Not Provided	☐ African ☐ Asian-Indian ☐ Cambodian ☐ Chinese ☐ Eskimo ☐ Fijian	☐ Filipino ☐ Guamanian (Guam) ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean	☐ Laotian ☐ Pakistani ☐ Samoan ☐ Thai ☐ Tongan ☐ Vietnamese
Ethnicity (check one)	☐ Hispanic or Latino	☐ Non-Hispanic or Latino		☐ Not Provided
Preferred Language	☐ English	☐ Spanish	☐ Vietnamese	☐ Other: _____
Smoking History	I currently smoke ☐ Yes ☐ No	Number of packs/day: _____	Number of years: _____	
	I used to smoke ☐ Yes ☐ No	Number of packs/day: _____	Number of years: _____ When did you stop? _____	
Allergies ☐ None				
Have you had a flu shot this season? (Sept 2015 thru March 2016) Yes ☐ No ☐		If yes, where?		
Referring Physician:		CCK Physician:		

Medications currently being taken (if more space is needed, use the back of this page). You do not need to include the chemotherapy drugs received in the treatment room. Include **ALL** vitamins and herbal supplements.

Drug	**Dose**	**Frequency**	**Date Started**	**Reason for Taking**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Preferred Pharmacy Name / Location	