Cancer Center of Kansas

HEALTH HISTORY QUESTIONNAIRE

(Please use blue or black ink, no pencil)

Name: ________________________ Date: ________________ Religion: ________________

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

Occupation: ________________________ Date of Birth: ________________

Place of Work: ________________________

SURGICAL HISTORY (Check any surgeries YOU have had):

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

HOSPITALIZATION HISTORY (other than for surgery): ________________________

PAST ILLNESSES (Check any illnesses YOU have or have had):

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

Other: ________________________

FAMILY HEALTH HISTORY

Relative		Age	List any Diseases (including Type of Cancer or Blood Disorders)	If Deceased, Cause of Death
Father				
Mother				
Father's Parents	Mother			
	Father			
Mother's Parents	Mother			
	Father			
Brothers				
Sisters				
Children:				
First Cousins:				

Cancer Center of Kansas

Patient 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? ______________________________________

DIAGNOSTIC TESTS

Are you claustrophobic? Yes / No Do you have a defibrillator? Yes / No Pacemaker? Yes / No

Do you have any metal or implant in your body? Yes / No If yes, where: ____________________________

When was your last chest x-ray? ______ /______ /_______ ☐ Never had one

When did you last have any lab testing? ______ /______ /_______ ☐ Never had one

When was your last colonoscopy? ______ /______ /_______ ☐ Never had one

When was your last EGD? ______ /______ /_______ ☐ Never had one

When was your last dexa scan? ______ /______ /_______ ☐ Never had one

When was your last CT or PET scan? ______ /______ /_______ ☐ Never had one

Have you had contrast dye? Yes / No Are you allergic to contrast dye? Yes / No

Type of Reaction: ____

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? ______ /______ /______ ☐ Never had one

When was your last mammogram? ______ /______ /_______ ☐ Never 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 many pounds 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

I have provided a copy of the above, if applicable: Yes / No