Tuality/OHSU CANCER CENTER
A collaboration of Tuality Healthcare and Oregon Health & Science University

Patient Medical History Questionnaire

FOR NURSE'S USE
Initials
Weight
BP
Pulse
Resp
Temp

Date: ______________________________

Instructions: please answer these questions as accurately as possible, since this will help your doctor evaluate your illness. All information is confidential and will not be released without your written permission.

Last Name		First		Middle (Maiden)
Address	City	State	Zip	Telephone Email Address:
Spouse's Name		Occupation (if retired, former occupation)		
Employer		Your Referring Doctor:	City/State:	

Sex
- ❑ Male
- ❑ Female

Marital Status
- ❑ Single ❑ Widowed
- ❑ Married ❑ Divorced

SS#

Other Doctors who might be interested in letters about progress

Name:	Address:
Name:	Address:

PERSONAL HISTORY

Do you regularly smoke cigarettes? ❑ Yes ❑ No Cigars? ❑ Yes ❑ No Pipes? ❑ Yes ❑ No Chew/Dip? ❑ Yes ❑ No

How many per day? __________ For how many years?__________ Would you like counseling to quit smoking? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Yes ❑ No What Kind? ____________________ How often? ______________

Have you ever used marijuana? ❑ Yes ❑ No Have you ever used street drugs? ❑ Yes ❑ No

Education: (circle highest) 1 2 3 4 5 6 7 8 Elementary 1 2 3 4 High School 1 2 3 4 over 4 College Other

Date of Birth: ______________________ (MONTH DAY YEAR) Place ______________________ (CITY STATE COUNTRY)

Place where raised: ____________________ Military Service:____________________

Next of kin or close friend (other than spouse) who will always know your whereabouts:

Name: ______________________ Telephone: ______________________

Address: ______________________ Relationship: ______________________

Name: ______________________ Telephone: ______________________

Address: ______________________ Relationship: ______________________

FAMILY HISTORY List age, status, & diseases

Relation	Age	Medical Problems	If Deceased, Age and cause of Death
Father:			
Mother:			
Wife or Husband			
Brothers: #			
Sisters: #			

Physician Signature: ______________________ **Date:**______________

MEDICAL HISTORY

Past illness or chronic medical problems (year and type) ______________________________

____

____

Past serious injuries (year and type) ______________________________

____

____

Past operations (year and type) ______________________________

____

____

Hospitalizations (name and location of hospital; date and reason) ______________________________

____

____

Have you recently (within the past 3 months) had:

Exam	Yes	No	Where? (Facility)
Chest x-ray			
Bone or liver scan			
Brain scan (CT or MRI)			
Kidney X-ray (IVP)			
Bone X-ray			

What is your usual weight?__________ Have you lost weight in the last 6 months? ______________________

Medicines you are now taking: Pharmacy: ______________________ Location:______________________

Drug Name	Dose:	Frequency	For What

Allergies to medicines:

Name	What happens to you when you take it?

Do you have:

Yes	No	Fever	Yes	No	Abdominal pain
Yes	No	Weight change	Yes	No	Vomiting blood
Yes	No	Fatigue	Yes	No	Blood in stool
Yes	No	Change in visual acuity	Yes	No	Black or tarry stool
Yes	No	Blind Spots	Yes	No	Change in stool caliber
Yes	No	Double Vision	Yes	No	Constipation
Yes	No	Change in hearing	Yes	No	Jaundice
Yes	No	Pain or discharge from ears	Yes	No	Bowel incontinence
Yes	No	Dizziness	Yes	No	Inflammatory bowel disease Crohn's disease, ulcerative colitis
Yes	No	Nose Bleeds	Yes	No	Pain in testicles
Yes	No	Sore of tongue or mouth	Yes	No	Scrotal masses
Yes	No	Bleeding from mouth	Yes	No	Impotency
Yes	No	Hoarseness or voice change	Yes	No	History of Adrogen Deprivation Therapy
Yes	No	Difficulty swallowing	Yes	No	Urinary hesitancy
Yes	No	Painful swallowing	Yes	No	Urinary frequency
Yes	No	Lumps or swelling in neck	Yes	No	Flow and volume of urine
Yes	No	Heart disease	Yes	No	Decreased urinary stream
Yes	No	Chest Pain	Yes	No	Burning on urination
Yes	No	Ankle swelling	Yes	No	Blood in urine
Yes	No	Pain in legs when walking	Yes	No	Hot flashes
Yes	No	Pneumonia	Yes	No	Irregular menstrual bleeding
Yes	No	Tuberculosis (now or in past)	Yes	No	Vaginal discharge
Yes	No	New cough	Yes	No	Bleeding after menopause
Yes	No	Coughing blood	Yes	No	Painful periods
Yes	No	Wheezing	Yes	No	History of Hormonal Replacement Therapy
Yes	No	Shortness of breath	Yes	No	Muscle weakness
Yes	No	Change in Appetite	Yes	No	Bone or joint pain
Yes	No	Nausea	Yes	No	New rashes
Yes	No	Diarrhea	Yes	No	Sores, bumps, lumps or change in pigmented areas

Yes	No	Breast Pain	Yes	No	Depression
Yes	No	Breast lumps	Yes	No	Sleep Disturbance
Yes	No	Nipple discharge	Yes	No	Intolerance to heat and cold
Yes	No	Headaches	Yes	No	Excessive thirst
Yes	No	Seizures	Yes	No	Hunger
Yes	No	Weakness	Yes	No	Easy bruising
Yes	No	Numbness/tingling	Yes	No	Abnormal bleeding
Yes	No	Memory loss	Yes	No	Collagen vascular disease

Pregnancies (number)_______ Miscarriages (number)________ Last menstrual period (date) _____________

Could you be pregnant:______ Date of your last mammogram ________ Date of last pap Smear ___________

Have you ever had any x-ray treatments *including treatment for birthmarks, acne, etc), radiation, cobalt or chemotherapy treatments? Yes No

Please outline the nature of the illness for which you have been referred to this department. Be as specific as possible and include information about the onset of symptoms, tests, biopsies, surgery or chemotherapy.

____

____

____

Do you have any pain? Yes No If yes, please circle where you are on a scale of 1-10

No pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Location: ____

What makes it worse:____

What makes it better: ____

What medication are you taking for pain: ____

Please mark an X on the picture where you have pain