Dayspring Cancer Clinic

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):			**Today's Date**	
Address (Streeet &Apt):			M F	**Age:**
(City, State, Zip):			**Date of birth**	
Email:			**Occupation**	
Phone:	Home:	Work:	**Employer**	
Marital Status:	Single Partnered Married Separated Divorced Widowed			
Children (Names, Ages)				
Name of Significant Other:				
Previous or referring doctor:		**Date of last physical exam:**		
How did you hear about me?				

Reason for visit, listed in order of importance:

1. _____
2. _____
3. _____
4. _____

Please list any medical problems that other physicians have diagnosed: _____
_____
_____
_____
_____

Describe your interests, hobbies, spiritual practices, things you do to relax _____
_____
_____
_____
_____

Medication allergies (including reaction when taken): _____
_____

Please list ALL medicines, prescribed and over the counter (OTC), including vitamins, herbs, homeopathics, Etc. or check [ ] if you do not take medicine regularly.
Attach a separate page if necessary.

Medicine	Strength	Times/Day	Reason	Prescriber

Family Health History					
	Age	**Significant Health Problems**			**Significant Health Problems**
Father					
Mother					
Sibling			M F		
			M F		
			M F	**Grandmother** Maternal	
			M F	**Grandfather** Maternal	
			M F	**Grandmother** Paternal	
			M F	**Grandfather** Paternal	

Name: _____ DOB: _____

Last, First MI

Surgeries/Hospitalizations		
Year	**Reason**	**Hospital**

Health Habits and Personal Safety								
Exercise	☐ Sedentary (no exercise)							
	☐ Mild exercise (e.g., climb stairs, walk three blocks, golf)							
	☐ Occasional vigorous exercise (e.g., work or recreation, less than 4x/week for 30 minutes each time)							
	☐ Regular vigorous exercise (e.g., work or recreation, at least 4x/week for 30 minutes each time)							
Diet	Number of meals you eat in an average day? _____							
Typical Day's Diet	Breakfast: _____							
	Lunch: _____							
	Dinner: _____							
	Snacks: _____							
Caffeine	☐ None	☐ Coffee, # cups per day _____		☐ Tea, # of cups per day _____		☐ Cola, # of cans per day _____		
Alcohol	Do you drink alcohol?	☐ Y es	☐ No	If yes, how many drinks per week? _____				
	Are you concerned about the amount you drink?	☐ Y es	☐ No	Have you considered stopping?	☐ Yes	☐ No		
	Drive after drinking?	☐ Y es	☐ No	Are you prone to binge drinking?	☐ Y es	☐ No		
Tobacco	Do you use tobacco?	☐ Y es	☐ No	Cigarettes, pks/day _____	Chew, _____	Cigars, #/day _____		
Illegal Drugs	Do you currently use recreational or street drugs?			☐ Y es	☐ No	If yes, which kinds and how often? _____		
Sex	Are you sexually active?			☐ Y es	☐ No	If yes, are you trying for pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy, list contraception method used_____					Any discomfort with intercourse?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Y es	☐ No	With whom do you live? _____				
	Physical and/or mental abuse have become major public health issue in this country. This often take the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this with the doctor?				☐ Yes	☐ No		

Name: _____ DOB: _____

Last, First MI

Mental Health		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic (anxiety) when stressed?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Review of Systems	
Weight	Present weight: _____ Weight one month ago: _____ Weight one year ago: _____
	Maximum weight and when: _____ _____ Minimum weight as adult and when: _____ _____
Height	Your current height: _____

REGARDING THE NEXT LONG SECTION: Please circle (**Y**) if you have the problem **CURRENTLY**, (**N**) if you have **NEVER** had the problem and (**P**) if you had the problem in the **PAST**.

Good energy: Y N P
Fatigue: Y N P
If you have fatigue, when does it affect you most, morning, afternoon, and/or evening? _____
_____

SKIN

Rash: Y N P
Hives: Y N P
Psoriasis: Y N P
Eczema: Y N P
Dry: Y N P
Cancer of skin: Y N P
Color change: Y N P
Lump: Y N P
Itchy: Y N P
Warts/moles: Y N P
Perspiration: Y N P

HEAD

Headache: Y N P
Dandruff: Y N P
Oily hair: Y N P
Dry hair: Y N P
Migraine: Y N P
Head injury: Y N P
Hair loss: Y N P

NOSE

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P
Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

EYES

Dry eyes: Y N P
Watery eyes: Y N P
Double vision: Y N P
Glaucoma: Y N P
Eye strain: Y N P
Itchy: Y N P
Blurry vision: Y N P
Cataracts: Y N P
Discharge: Y N P
Dark under eyelids: Y N P

Name: _____ DOB: _____
Last, First MI

MOUTH/THROAT

Canker sores:	Y	N	P	Cold sores (fever blisters):	Y	N	P
Sore throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Hoarseness:	Y	N	P
Diffuculty swallowing:	Y	N	P				

NECK

Stiffness:	Y	N	P	Tension:	Y	N	P
Swollen glands:	Y	N	P				

RESPIRATORY

Cough:	Y	N	P	Wheezing:	Y	N	P
Shortness of breath				TB:	Y	N	P
with exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath				Pneumonia:	Y	N	P
when sitting:	Y	N	P	Asthma:	Y	N	P
Shortness of breath				Painful breathing:	Y	N	P
when lying down:	Y	N	P				

CARDIOVASCULAR

High blood pressure:	Y	N	P	Rheumatic fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

GASTROINTESTINAL

Heartburn:	Y	N	P	Bowel movement frequency: _____			
Indigestion:	Y	N	P	Recent BM change:	Y	N	P
Bloating:	Y	N	P	Diarrhea:	Y	N	P
Nausea:	Y	N	P	Constipation:	Y	N	P
Vomiting:	Y	N	P	Hemorrhoids:	Y	N	P
Change in appetite:	Y	N	P	Liver/gall bladder disease:	Y	N	P
Pancreatitis:	Y	N	P	Ulcer:	Y	N	P

MUSCULOSKELETAL

Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P

NERVOUS

Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel syndrome:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P

URINARY TRACT

Incontinence:	Y	N	P	Pain with urination:	Y	N	P
Frequent infections:	Y	N	P	Kidney stones:	Y	N	P
Urgency:	Y	N	P	Discharge/blood:	Y	N	P

Name: _____ DOB: _____
Last, First MI

MALE GENITALIA

Testicular pain/swelling:	Y	N	P	Discharge:	Y	N	P
STD:	Y	N	P	Impotency:	Y	N	P
Hernia:	Y	N	P	Prostate disease:	Y	N	P

FEMALE GENITALIA

Age period began:	_____			How often period occurs:	_____		
How long period lasts:	_____			Heavy menstrual bleeding:	Y	N	P
Menstrual cramping:	Y	N	P	Menstrual pain:	Y	N	P
PMS:	Y	N	P	Food cravings:	Y	N	P
Number of pregnancies:	_____			Healthy libido:	Y	N	P
Number of births:	_____			Vaginitis:	Y	N	P
Number of miscarriages:	_____			Mammography:	Y	N	P
Last pap smear:	_____			Vaginal dryness:	Y	N	P
Any abnormal paps:	Y	N	P	Pain with intercourse:	Y	N	P
Menopause since what age:	_____			STD:	Y	N	P
Hormone replacement:	Y	N	P				

Please list any birth control usage including ages used: _____
_____

MENTAL/EMOTIONAL

Depression:	Y	N	P	Anger/irritability:	Y	N	P
Suicidal:	Y	N	P	Tense:	Y	N	P
Anxiety:	Y	N	P	Fear/panic:	Y	N	P
Eating disorder:	Y	N	P	Psyc hospitilization:	Y	N	P

SLEEP

How long per night: _____ If you wake frequently, what is the reason? _____

Nightmares:	Y	N	P	Wake refreshed:	Y	N	P
Sleep walk:	Y	N	P	Grind teeth:	Y	N	P
Must nap during day:	Y	N	P	Snore:	Y	N	P

Please include any concerns you have that have not been asked above, here: _____
_____
_____
_____
_____
_____
_____
_____

SIGNATURE: The information provided above is correct to the best of my knowledge:

_____Print Name_____

Date_____

Thank you for taking the time to thoughtfully and completely answer the above questions
This is the first step towards better health!

Release of Your Health Information

Who may receive information regarding your Protected Health Information?
(Check all that apply)

Spouse Yes No Name: _____ Birth date: _____

Children Yes No Name: _____ Birth date: _____

Name: _____ Birth date: _____

Name: _____ Birth date: _____

Other Yes No Name: _____ Birth date: _____

Name: _____ Birth date: _____

Name: _____ Birth date: _____

This authorization may be revoked at any time by submitting a written notification to Dayspring Cancer Clinic.

May we leave messages regarding appointments and other health information on your answering machine/voice mail?

Yes _____ No _____

Signature of Patient or legally authorized individual **Date**

Name and relationship to patient if signed by anyone other than the patient
(Parent, legal guardian, personal representative, etc)