HEALTH QUESTIONNAIRE
ANN PITTIER, MD / WENDY GAO, MD

Name:_____ Today's date: _____

Date of Birth:_____Age:_____

Please complete and return this form at the time of your appointment. This will be extremely helpful to the doctor. All information is confidential.

CHIEF COMPLAINT: What is your CURRENT most important medical problem?

_____

Who referred you to this doctor?_____

Please list doctors that should receive a copy of this consultation:_____

List your primary phone number:_____ Permission to leave message?_____
Permission to talk to family member about your diagnosis?_____

MEDICATIONS: Please list all current medications, vitamins, hormones (prescription and non-prescription).

MEDICATION NAME	DOSAGE (mg, mEq)	How often taken?	How long have you been taking this medication?

Which pharmacy to you use?_____
Location of pharmacy_____

Please list ALLERGIES to Medication and the associated reaction:
_____
_____

Flu Shot: Yes/ No Approximate date _____
Pneumonia Shot: Yes/ No Approximate date _____

MEDICAL HISTORY: (past and present) _____
_____
_____

OPERATIONS:

Operations	Date	Hospital	Surgeon

PERSONAL CANCER HISTORY: _____
_____

PREVIOUS RADIATION THERAPY? YES_____NO_____

WHERE	WHEN	WHY	DOCTOR

PREVIOUS CHEMOTHERAPY? YES_____NO_____
DATE OF YOUR LAST COURSE OF CHEMOTHERAPY?_____

INJURIES: (fractures, head injury, burns, etc.)
_____
_____

PERSONAL HISTORY:

Occupation:_____

Retired? YES_____ NO_____

Are you: Single _____Married _____Divorced _____Widowed_____

Living with Spouse? YES_____ NO_____

Do you live with anyone else besides your spouse: (children, parents, significant other)

Names and relationship:_____

Education:_____

Have you completed a Living Will or advance directive? YES_____NO_____

Typically we do not match genders when providing care. However, if you have special considerations, please let your physician or nursing staff know. We will do our best to meet your needs.

DAILY HABITS:

1: Are you on any special diet? YES_____NO_____If so, what kind of diet?_____
2: Do you use alcohol: YES_____NO____How much?_____
3: Past heavy alcohol use? YES_____NO____
4: Have you used recreational or illegal drugs? YES_____NO_____
5: Are you at increased risk of HIV or AIDS? YES_____NO_____
6: Asbestos exposure? YES_____ NO_____ WHERE_____
7: Chemical exposure? YES_____NO_____WHAT KIND?_____
8: Have you ever smoked? YES ____NO ____How much?_____
For how many years? _____When did you quit?_____

FAMILY HISTORY:

Has anyone in your family been diagnosed with cancer? YES_____NO____

If yes, describe how the person is related to you, and what type of cancer, ie, breast, lung, brain, etc._____
_____
_____
_____

SYMPTOM REVIEW:
Do you currently have any of the following problems? Please circle:

General:
Recent symptoms of:

a. chills
b. fever
c. sweats
d. changes in weight
e. fatigue
f. nervousness
g. insomnia, difficulty sleeping
h. sadness, crying or depression

Comments:_____

Cardiovascular:

a. chest pain
b. palpitations
c. murmur
d. cramping in legs when you walk
e. swelling
f. abnormal EKG

Do you have a cardiac pacemaker or defibrillator device? YES_____ NO_____
If yes, what is the manufacturer ID number? _____

Comments:

Respiratory:

a. cough
b. blood tinges phlegm
c. wheezing
d. short of breath with exertion
e. abnormal chest x-ray

Comments:

_____
_____

Gastrointestinal:

a. vomiting of blood
b. bloody stools, black stools
c. difficulty swallowing
d. jaundice
e. gallbladder trouble
f. diverticulitis
g. colitis
h. diarrhea
i. constipation
j. hemorrhoids
k. nausea
l. heartburn
m. abdominal pain

Comments:

_____

_____

Genitourinary:

a. urinary frequency during the day
b. urination at night ___times
c. trouble starting urination
d. painful urination
e. urgency
f. decreased stream
g. blood in urine
h. urinary infections
i. urinary stones
j. prostate disease
k. testicle lumps

Comments:

_____

Metabolic:

a. heat or cold intolerance
b. goiter
c. excessive thirst
d. history of diabetes

Comments:_____

_____

Hematologic:

a. anemia
b. blood transfusions
c. bleeding tendency
d. easy bruising
e. blood clotting trouble

Comments: _____

_____

Skin:

a. rash
b. changing moles
c. skin trouble/eczema

Comments:_____
_____

Neurologic:

a. headache
b. stroke
c. seizures
d. passing out
e. localized weakness or loss of muscle function
f. localized numbness or loss of muscle sensation

Comments:_____

Musculoskeletal:

a. bone pain
b. arthritis
c. broken bones
d. muscle ache
e. back pain

Comments:_____

GENERAL:

Any additional information you feel the doctor should know:_____

_____

Women only:

GYNECOLOGIC:

Is there any possibility you are pregnant? YES_____NO____

Number of pregnancies_____

Number of deliveries_____

Age at 1st menstrual period_____

At what age was your 1st live child birth _____

Women Only (continued):

Age at menopause_____

Have you had a hysterectomy_____ At what age_____

Were ovaries removed_____

Reason for operation_____

Do you have current menopausal symptoms (hot flashes)_____

Have you taken Hormone Replacement Therapy _____

How many years_____

When did you quit_____

Do you have a family history of breast or ovarian cancer _____

Do you have a first-degree relative with breast or ovarian cancer (mother and/or sisters, daughters)_____

Prior to this diagnosis have you ever had a breast biopsy before? _____

(For Physician's Use Only)
KARNOFSKY PERFORMANCE SCORE: _____

_____ _____
Physician Signature Date: