HEALTH QUESTIONNAIRE Dean Mastras, MD

NAME:_____Today's Date:_____

Date of Birth:_____Age:_____

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

Who is your family doctor?_____Dentist:_____

Chief Complaint: What is your CURRENT most important medical problem?_____

_____

_____

Who referred you to our practice?_____

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 do you use?			
Location:			

PLEASE LIST ALLERGIES (food, medications, etc.)

_____

_____

_____

Flu Shot: Yes/ No Approximate date _____

Pneumonia Shot: Yes/ No Approximate date _____

Operations:

Operation	Date	Hospital	Surgeon

Serious Illnesses:
Do you currently have any of the following problems? Please circle.

a. diabetes
b. stroke
c. tuberculosis
d. high blood pressure
e. heart disease-heart attack/failure
f. kidney disease
g. liver disease
i. asthma
j. stomach, esophageal or bowel disease
k. thyroid disease
l. other serious illness_____
_____
m. significant infections or transfusions
n. collagen disease- ie: Lupus_____

Injuries: (fractures, head injury, burns, etc)

_____

_____

Previous Radiation Therapy? Yes_____ No_____
If yes:

Where	When	Why	Doctor

Previous Chemotherapy? Yes____ No____

Date of your last course:_____

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, parent, significant other)

Names and relationship:_____

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.

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.

Father's Age: Status: Living/Dead Major Illnesses:_____
_____

Mother's Age: Status: Living/Dead Major Illnesses:_____
_____

Number of Brothers:_____Number of Sisters:_____

Daily Habits:

1. Have you ever smoked? Yes___No___ How much?_____
   When did you start?_____When did you stop?_____
2. Are you any special diet? Yes____No____If so, what kind of diet? _____

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3. Do you use alcohol? Yes___ No___ How much? _____
4. Past heavy alcohol use? Yes___ No___
5. Have you used recreational or illegal drugs? Yes___ No___
6. Are you at increased risk of HIV or AIDS? Yes____No____
7. Asbestos exposure? Yes___ No___ Where_____
8. Chemical exposure? Yes___ No___What kind?_____

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:_____
_____

EYES:
a. eye pain
b. double vision
c. flashing lights, halos, etc
d. blind spots

Ear, Nose and Throat:
a. deafness
b. ringing in ears
c. nose bleeds
d. significant nasal discharge
e. dental problems
f. painful swallowing
g. trouble swallowing/food getting stuck
h. hoarseness or voice change
i. spitting up blood
j. dentures

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 tinged 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 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

MEN ONLY:

a. prostate disease
b. able to have an erection
c. testicle lumps

Comments:_____
_____

Metabolic:

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:_____

Women only: Men continue to **"General".**

Gynecologic:

Is there any possibility you are pregnant, or do you plan on becoming pregnant?
Yes__No__

a. last menstrual period_____
b. last pap smear_____
c. hysterectomy
d. menopausal symptoms
e. hormones
f. abnormal pap smear
g. family history of breast cancer
h. vaginal discharge or itching
i. number of pregnancies_____
j. number of miscarriages/abortions___
k. type of birth control_____
m. excessive flow or spotting between periods
n. excessively painful periods
o. mother took DES hormone during pregnancy

Comments:_____

Breast Health History:

Date of your last mammogram?_____
Do you perform Breast Self Examination? Yes_____ No_____
At what age was your first menstrual period?_____
At what age was your first live child birth?_____
Do you have a first degree relative with breast cancer (mother and/or sisters, daughters)?

Have you had a previous breast biopsy? Yes____No_____
Do you have a history of in situ breast cancer? Yes____No____
Have you even taken estrogen replacement hormones? Yes___ No____
If yes, when?_____

GENERAL:

Any additional information you feel the doctor should know:_____

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

Physician Signature Date