



# MONTANA CANCER CENTER HEALTH QUESTIONNAIRE

Temp \_\_\_\_\_  
Wt \_\_\_\_\_  
Ht \_\_\_\_\_  
BP \_\_\_\_\_  
P \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

GENERAL DOCTOR: \_\_\_\_\_ OTHER DOCTORS: \_\_\_\_\_ DENTIST: \_\_\_\_\_

MEDICAL/RADIATION ONCOLOGIST: \_\_\_\_\_ SURGEON: \_\_\_\_\_

Please tell us why you are here: \_\_\_\_\_

Please list any symptoms or problems you currently are having (e.g. fever, weight loss) \_\_\_\_\_

1) EYES, EARS, NOSE, THROAT AND MOUTH

- |                                |   |   |
|--------------------------------|---|---|
| Any problems with your eyes?   | Y | N |
| What: _____                    |   |   |
| Cataracts                      | Y | N |
| Glaucoma                       | Y | N |
| Any problems with your ears?   | Y | N |
| What: _____                    |   |   |
| Any problems with your nose?   | Y | N |
| What: _____                    |   |   |
| Any problems with your throat? | Y | N |
| What: _____                    |   |   |
| Any problems with your mouth?  | Y | N |
| What: _____                    |   |   |

2) CARDIOVASCULAR

- |                     |   |   |
|---------------------|---|---|
| High Blood Pressure | Y | N |
| Heart Attack        | Y | N |
| Heart Murmur        | Y | N |
| Chest pains, angina | Y | N |
| Heart disease       | Y | N |
| Bleeding tendency   | Y | N |
| Strokes/fainting    | Y | N |
| Anemia              | Y | N |

3) RESPIRATORY

- |                          |       |   |
|--------------------------|-------|---|
| Bronchitis               | Y     | N |
| Emphysema                | Y     | N |
| Asthma                   | Y     | N |
| Abnormal chest x-ray     | Y     | N |
| Cough                    | Y     | N |
| Coughing up blood        | Y     | N |
| Difficulty breathing     | Y     | N |
| Chest pain               | Y     | N |
| Wheezing                 | Y     | N |
| Date of last chest x-ray | _____ |   |

4) GASTROINTESTINAL

- |                        |                       |   |
|------------------------|-----------------------|---|
| Abdominal pain         | Y                     | N |
| Nausea                 | Y                     | N |
| Vomiting               | Y                     | N |
| Vomiting blood         | Y                     | N |
| Change in bowel habits | Y                     | N |
| Constipation           | Y                     | N |
| Diarrhea               | Y                     | N |
| Blood in stools        | Y                     | N |
| Jaundice, hepatitis    | Y                     | N |
| Liver disease          | Y                     | N |
| Stomach/bowel problems | Y                     | N |
| Weight loss/gain       | Loss _____ Gain _____ |   |

5) Have you ever had a blood transfusion? \_\_\_\_\_

If yes, when \_\_\_\_\_

6) When was your last vaccination? \_\_\_\_\_

7) Have you ever been vaccinated against Pneumonia? \_\_\_\_\_

If yes, when? \_\_\_\_\_

8) Influenza (Flu) \_\_\_\_\_ If yes, when? \_\_\_\_\_

9) URINARY

- |                              |   |   |
|------------------------------|---|---|
| Loss of Urine                | Y | N |
| Frequent urination           | Y | N |
| Nighttime urination          | Y | N |
| How frequent _____           |   |   |
| Blood in urine               | Y | N |
| Burning/painful urination    | Y | N |
| Kidney disease/insufficiency | Y | N |
| Sexually active              | Y | N |

10) MUSCULOSKELETAL

- |                 |   |   |
|-----------------|---|---|
| Muscle problems | Y | N |
| Joint problems  | Y | N |

11) SKIN

- |           |   |   |
|-----------|---|---|
| Problems? | Y | N |
|-----------|---|---|

12) NEUROLOGICAL

- |                                 |   |   |
|---------------------------------|---|---|
| Convulsions, seizures, epilepsy | Y | N |
|---------------------------------|---|---|

13) PSYCHIATRIC

- |                     |   |   |
|---------------------|---|---|
| Psychiatric therapy | Y | N |
|---------------------|---|---|

14) ENDOCRINE

- |                   |   |   |
|-------------------|---|---|
| Diabetes          | Y | N |
| Thyroid disease   | Y | N |
| Hormonal problems | Y | N |

15) GENITAL - FEMALE

- |                               |   |   |
|-------------------------------|---|---|
| Vaginal bleeding or discharge | Y | N |
| Do you menstruate?            | Y | N |
| Irregular periods             | Y | N |
| Painful periods               | Y | N |
| Painful intercourse           | Y | N |

Number of pregnancies: \_\_\_\_\_

Number of deliveries: \_\_\_\_\_

Date of last period: \_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_

Have you ever taken birth control or hormone pills?

Y      N      How long? \_\_\_\_\_

Name of pills: \_\_\_\_\_

ALLERGIES

- |                |   |   |       |
|----------------|---|---|-------|
| Penicillin     | Y | N | _____ |
| Codeine        | Y | N | _____ |
| Aspirin        | Y | N | _____ |
| Sulfa          | Y | N | _____ |
| Iodine         | Y | N | _____ |
| X-ray contrast | Y | N | _____ |
| Food allergy?  | Y | N | _____ |
| Others _____   |   |   | _____ |

What happened?

Do we have permission to discuss your case with members of your family?    Y    N

Who or who not: \_\_\_\_\_

**PREVIOUS MEDICAL HISTORY**

Please list all of your past serious illnesses/injuries/surgeries:

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Have you ever had any of the following:	Where	Dates	Doctors
Biopsies: _____			
Chemotherapy: _____			
Radiation therapy: _____			
Hormones: _____			

List all medications, vitamins and/or herbs you are currently taking: \_\_\_\_\_

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**HABITS**

	SMOKED		Chewed Tobacco		Drank Alcohol	
	Y	N	Y	N	Y	N
Do you or have your ever:						
How many years:						
Do you still:						
If you quit, when:						
How much per day:						
What type:						
Have you ever been told/asked to stop?						

**SOCIAL**

Do you drive?    Y   N                      Has anyone told you to stop?    Y   N

Are you:    Single    Married    Separated    Divorced    Widowed

Do you live alone?    Y   N

Do you have any children?    Y   N    How many? \_\_\_\_\_ Ages: \_\_\_\_\_

Do you have dependents at home? \_\_\_\_\_

Do you work:    Part time    Full time    Retired

Your past or present occupation? \_\_\_\_\_

Education:    Grade school    High school    College    Postgraduate

Do you have any difficulties reading?    Y   N

Is there any chance you are pregnant?    Y   N

**FAMILY HISTORY**

	Living/Dead	Age/Age at Death	Present Health/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse	_____	_____	_____
Brothers	No. Living _____		Health _____
	No. Dead _____		Cause of Death _____
Sisters	No. Living _____		Health _____
	No. Dead _____		Cause of Death _____
Children	No. Living _____		Health _____
	No. Dead _____		Cause of Death _____