UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

CANCER CENTER

4501 X STREET
Sacramento, CA 95817
(916) 734-5959 (Appt. Scheduling)

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME _____ **DATE** _____

I. A. What present medical problem causes you to seek medical help?

_____

_____

B. Describe when it started and how it started, symptoms, medications taken and results.

_____

_____

_____

C. Who are the doctors involved in your medical care?

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

II. PAST HISTORY: (check diseases you have had)

A. Infectious Diseases

- ❒ Measles
- ❒ Mumps
- ❒ Chicken pox
- ❒ Meningitis
- ❒ Syphilis
- ❒ Tuberculosis
- ❒ Scarlet Fever
- ❒ Small pox
- ❒ Whooping Cough
- ❒ Diphtheria
- ❒ Typhoid Fever
- ❒ Gonorrhea
- ❒ Fungal Disease
- ❒ Rheumatic Fever
- ❒ St. Vitus Dance
- ❒ Pneumonia
- ❒ Infectious Mononucleosis
- ❒ Infectious Hepatitis
- ❒ Amoeba

B. Operations/Medical Illnesses: (list) Year

_____

_____

_____

_____

C. Have you ever had a problem with general anesthesia?

_____

_____

D. Broken Bones/Accidents or Trauma:

_____

_____

E. Prior history of cancer? Yes ❒ No ❒

_____

F. Prior radiation therapy? Yes ❒ No ❒

G. Immunizations Year

- ❒ Diphtheria _____
- ❒ Pertussis _____
- ❒ Tetanus _____
- ❒ Typhoid _____
- ❒ Influenza _____

Immunizations Year

- ❒ Polio _____
- ❒ Measles _____
- ❒ Mumps _____
- ❒ Small pox _____

H. Do you have, or have you had any diseases not mentioned above?

_____

_____

III. SYSTEM REVIEW:

A. **GENERAL HEALTH:** Good ❒ Fair ❒ Bad ❒

Easily Fatigued: Yes ❒ No ❒
Night Sweats: Yes ❒ No ❒
Weight: Loss - how much _____
Gain - how much _____
Stable _____
Appetite: Good ❒ Fair ❒ Poor ❒
Sleep: Good ❒ Fair ❒ Poor ❒
Fevers: Yes ❒ No ❒

B. **GASTROINTESTINAL TRACT:** (check if "yes")
Have you ever been bothered with:

1. Sore, painful tongue ❒
2. Tongue enlargement ❒
3. Difficulty Swallowing ❒

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PATIENT QUESTIONNAIRE

B. GASTROINTESTINAL TRACT: (check if "yes") Cont'd

4. Pain in abdomen or abdominal cramps ❒
5. Yellow jaundice ❒
6. Nausea ❒
7. Vomiting and/or blood vomitus ❒
8. Diarrhea ❒
9. Constipation ❒
10. Bloody, tarry or clay colored BM's ❒
11. Excessive belching or gas ❒
12. Intolerance to foods ❒
13. Hemorrhoids ❒
14. Pressure sensation in chest or upper abdomen ❒
15. Stomach ulcers ❒
16. Gall bladder disease ❒

C. HEMATOLOGIC SYSTEM: (check if "yes")

Anemia ❒
Bleeding tendencies ❒
Blood disease ❒
Blood transfusions ❒
Date: _____
Any allergic reactions? Yes ❒ No ❒

D. CARDIOVASCULAR SYSTEM: (check if "yes")

Have you had or do you have:

1. Chest pain with/without exercise or excitement ❒
2. Shortness of breath with or without exercise ❒
3. Cough and/or sputum ❒
4. Wheezing in chest ❒
5. Can't lie flat to sleep ❒
6. Wake up at night short of breath ❒
7. Rapid and/or irregular heart beat ❒
8. Asthma or hay fever ❒
9. Heart attack ❒
10. High or low blood pressure ❒
11. Swelling in legs or feet, dropsy ❒

E. GENITO URINARY SYSTEM: (check if "yes")

1. Frequency ❒
2. Albumin or sugar in urine ❒
3. Urgency ❒
4. Trouble starting or stopping stream ❒
5. Incontinence ❒
6. Getting up at night to urinate ❒
7. Painful urination ❒
8. Venereal disease or bad blood ❒
9. Stricture ❒
10. Bleeding after intercourse ❒
11. Loss of interest in sex ❒
12. Kidney or bladder infection ❒
13. Kidney or bladder stones ❒

F. NEUROMUSCULAR MOTOR SYSTEM: (check if "yes")

❒ Muscle Paralysis
❒ Weakness
❒ Painful/Swollen Joints
❒ Double/Impaired Vision
❒ Headaches
❒ Ringing in Ears
❒ Dizziness
❒ Nervous Breakdown
❒ Weak Back
❒ Convulsions
❒ Unconsciousness
❒ Hearing Loss
❒ Fainting Spells
❒ Difficulty Keeping Equilibrium
❒ Shooting Pains in Legs
❒ Numbness or Tingling of Hands and Feet

G. FEMALE ONLY:

1. When did you first menstruate? _____
2. When did you stop menstruating? _____
3. Cycle -- Every _____ days. Last MP _____
4. Excessive or scanty bleeding? _____
5. Number of pregnancies___ Number of children____
   Number of miscarriages___ Number of abortions___
   Weight of largest baby at birth_____
6. Have you ever been treated for an abnormal pap smear? ❒
7. Date of last pap smear_____
8. Have you ever had a pelvic infection? ❒
9. Have you ever had a venereal disease? ❒
10. Do you practice monthly self-breast exams? ❒
11. Date of last mammograms _____

IV. FAMILY HISTORY:

Mother ❒ Living ❒ Dead Age_____
State of health/Cause of death_____
Father ❒ Living ❒ Dead Age_____
State of health/Cause of death_____
Brothers No. Living_____ No. Dead_____ Age_____
State of health/Cause of death_____
Sisters No. Living_____ No. Dead_____ Age_____
State of health/Cause of death_____

Is there a history of the following diseases in your family? Please check.

❒ Diabetes
❒ High Blood Pressure
❒ Strokes
❒ Tuberculosis
❒ Heart Attacks
❒ Epilepsy
❒ Alcoholism
❒ Cancer
❒ Kidney or Bright's Disease
❒ Rheumatic Fever
❒ Bleeding Tendency
❒ Arthritis and/or Gout
❒ Asthma
❒ Dropsy
❒ Nervous Breakdowns

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PATIENT QUESTIONNAIRE

V. PERSONAL HISTORY

Birthdate:_____ Birthplace:_____

Education (highest): _____

Occupation:_____

Have you ever lived outside the United States? ❒ Yes ❒ No

If so, where and for how long? _____

Military Service: When _____

What did you do?_____

Highest Rank attained _____

Married _____ years Age of Spouse _____ Health of Spouse _____

Number of Children_____ Ages_____ Sexes_____

Medications:

Medications taken on a regular basis including aspirin and aspirin-containing products_____

_____

Medications you are allergic to_____

_____

VI. SOCIAL HABITS

Smokes _____ cigarettes/day
_____ cigars/day
_____ lbs. chewing tobacco/week

Alcohol intake _____Daily _____Weekly _____On Occasion

VII. PERSONAL LIFESTYLE

Do you worry a great deal? ❒ Yes ❒ No

Fearful? ❒ Yes ❒ No

Like yourself? ❒ Yes ❒ No

Like to be around others? ❒ Yes ❒ No

Get depressed? ❒ Yes ❒ No

Like your work? ❒ Yes ❒ No

Have hobbies? ❒ Yes ❒ No

Do you have any spiritual support? ❒ Yes ❒ No

Have pets? ❒ Yes ❒ No

Have good communications with your Spouse? ❒ Yes ❒ No ❒ Sometimes