NORTHEAST OKLAHOMA
CANCER CENTER

HEALTH QUESTIONNAIRE (*Please complete this form and bring to your first appointment*)

PATIENT INFORMATION (*Please print)*

Name: _____ Date of Birth: _____ Sex: ☐ M ☐F

Social Security Number: _____ Phone Number(Home) _____

Phone Number (Cell) _____ Phone Number(Message) _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Email Address: _____

Currently Employed: ☐ Yes ☐ No ☐ Part Time ☐ Full Time

Employer: _____ Business Phone: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

INSURANCE INFORMATION

Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Social Security Number: _____

Policy Holder Employer: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Reason for Visit: _____

Referring Doctor: _____

Do you have a Home Health Company? _____

If HOSPICE is involved in your healthcare, what Company? _____

Current Living Arrangements: _____

Who is your Primary Care Physician? _____

Other Physicians involved in your care? _____

Pharmacy Name: _____

Pharmacy Phone: _____

Exposure to any Hazardous/Toxic Materials: _____

Have you fallen in the last three (3) months? ☐ Yes ☐ No

Do you require assistive devices such as a cane, walker, etc.? ☐ Yes ☐ No

If so, please list: _____

Do you have any concerns with transportation, home care assistance, health care expenses, support groups, and counseling? ☐ Yes ☐ No

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GENERAL CONDITION Please check (✓) the single most appropriate response.

MY CURRENT HEALTH ALLOWS ME TO:

□ Be fully active and carry on all normal activities.

□ Perform activities such as light house work, office work, shopping, etc. but not perform strenuous activities.

□ Take care of myself but not perform light work. I am out of bed more than half of the day, and I get out of the house.

□ Stay pretty much at home, in a bed or a chair more than half of the day, but I'm able to take care of myself to some degree.

□ Be confined to a chair or bed all of the time.

MY PAIN. I AM HAVING:

□ No pain.

□ Mild pain, requiring little or no medication.

□ Moderate pain, requiring regular medication.

□ Severe pain, requiring regular strong pain medication such as narcotics.

MY PAIN IS:

□ Controlled

□ Uncontrolled

MY PAIN IS LOCATED:

PLEASE LIST ALL MEDICAL DIAGNOSIS/CHRONIC MEDICAL CONDITIONS

PLEASE LIST ALL ALLERGIES AND REACTIONS TO ALL DRUGS, FOODS, DYES, ETC.

Have you had the FLU shot this year? □ Yes □ No When:

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Have you ever had cancer before? ☐ Yes ☐ No If yes: What kind? _____

When? _____ Where were you treated? _____

By whom were you treated? _____

Have you ever received radiation? ☐ Yes ☐ No If yes: Why? _____

When? _____

Where? _____

LIST ANY/ALL FAMILY WITH HISTORY OF CANCER (Including maternal and paternal relations)

Relation	Type of Cancer	Current Age	Date of Death

WOMEN

Of Pregnancies _____ # Of Children _____

Are you still having normal menstrual periods? ☐ Yes ☐ No If yes, when was your last period _____

Are your periods: ☐ Regular ☐ Irregular

Do you have spotting or bleeding between periods? ☐ Yes ☐ No

Method of birth control? _____

At what age did you stop having your menstrual periods? _____

Have you had abnormal bleeding recently? ☐ Yes ☐ No

Have you had an abnormal pap smear? ☐ Yes ☐ No If yes, when? _____

MEN

Have you had a PSA level drawn? ☐ Yes ☐ No

When was your last PSA done (date)? _____

Do you have erectile dysfunction? ☐ Yes ☐ No

Age at time of erectile dysfunction? _____

List any medications or procedures you have received for erectile dysfunction and when they were received.

_____

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SOCIAL HISTORY

Have you ever smoked? ☐ Yes ☐ No How many packs per day? _____

What age did you start smoking? _____

Do you still smoke? ☐ Yes ☐ No If no, when did you quit? _____

Have you ever chewed/dip tobacco? ☐ Yes ☐ No How many cans per day? _____

What age did you start to chew/dip? _____

Do you still chew tobacco? ☐ Yes ☐ No How many cans per day? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____

Did you drink in the past? ☐ Yes ☐ No How many drinks per day? _____

Do you experience insomnia? ☐ Yes ☐ No

Do you have difficulty going to sleep? ☐ Yes ☐ No

Do you have difficulty staying asleep? ☐ Yes ☐ No

Describe past history of sun exposure: _____

Any weight changes in the last three (3) months? ☐ Yes ☐ No

If yes, amount of weight loss_____ or gain_____?

Do you have any autoimmune disorders? ☐ Yes ☐ No If yes: _____

Have you had a colonoscopy in the past? ☐ Yes ☐ No If yes: When?_____

What were the results? _____

Any rashes or sores? ☐ Yes ☐ No If so, where? _____

Any healing incisions and location: _____

Any Edema, or lymphedema and locations:

_____

Any seizures? ☐ Yes ☐ No How often? _____ Date of last seizure you had? _____

Recent or sudden memory loss? ☐ Yes ☐ No

Skeletal pain or arthritis? ☐ Yes ☐ No Where? _____

How often? _____

Weakness in arms or legs? ☐ Yes ☐ No Where? _____

How often? _____

Dizzy or lightheaded upon standing? ☐ Yes ☐ No How often? _____

Able to perform full range of motion? ☐ Yes ☐ No If no, describe limitations: _____

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HEALTH PROBLEMS Have you had any of the following problems?					
Decreased visual acuity	☐ Yes	☐ No	Blurred vision	☐ Yes	☐ No
Blind	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Enucleation	☐ Yes	☐ No
Chronic eye disease	☐ Yes	☐ No	Hearing loss	☐ Yes	☐ No
Hearing aid	☐ Yes	☐ No	Tinnitus	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	Dentures	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No	Bleeding of mouth/gums	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Oxygen use	☐ Yes	☐ No
Sleep sitting up	☐ Yes	☐ No	Cough up blood	☐ Yes	☐ No
Obstructed breath	☐ Yes	☐ No	Other respiratory problems	☐ Yes	☐ No
History of cardiovascular	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Angina	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Loss of appetite	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
Vomiting blood	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Acid reflux	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Changes in stools	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No	Bowel incontinence	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Gastric obstruction	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No	Urgency	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No	Difficulty urinating	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No	Urinate frequently at night	☐ Yes	☐ No
History of skin lesions	☐ Yes	☐ No	Rashes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Difficulty walking	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seasonal allergies	☐ Yes	☐ No