PROVIDENCE Saint John's Health Center

JOHN WAYNE CANCER INSTITUTE at Providence Saint John's Health Center

JOHN WAYNE CANCER CLINIC

MEDICAL QUESTIONNAIRE

Date: _____

Name: _____ Gender: ☐ Male ☐ Female Age: _____
(Last) (First) (Middle)
Home Address: _____City: _____State: ____Zip-code: _____

Phone: _____ Fax No. (if any): _____

Date of birth:_____ Birth place: _____ Mother's birth name: _____

Social Security Number: _____- _____-_____ Driver's License No. _____

Height: _____ Weight:____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed

Spouse's Name: _____ Married how long? _____ Language spoken: _____

Interpreter required: ☐ Yes ☐ No

Occupation: _____ Employer: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip-code_____ Fax: _____

Emergency Contact: _____ Relationship: _____
Home Address: _____City: _____ State: _____ Zip code:_____
Phone: _____ Fax No. (if any): _____
Local telephone number (Relative, Friend or Hotel): _____

Referring Physician: _____ Specialty: _____
Address: _____City: _____ State: _____ Zip-code: _____
Phone: _____ Fax No.: _____

Other Physician: _____ Specialty: _____
Address: _____City: _____ State: _____ Zip-code: _____
Phone: _____ Fax No.: _____

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Name: _____ Date: _____/_____/_____

The following information will help us evaluate our treatment of melanoma. Each question has a purpose in this evaluation. It is important that you answer as accurately as you can. Your help is greatly appreciated.

(Please check one)
Has any blood relative had melanoma? ☐ Yes ☐ No
If yes, what is the elationship?_____

What is your ethnic background?

Ethnicity: ☐ White/Caucasian ☐ Black/African-American ☐ Native Hawaiian or other Pacific Islander ☐ Ashkenazi Jewish Heritage

☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic/Latina ☐Other:_____

Please list your occupation or kinds of work you have done: _____
_____

What is your eye color? ☐ Blue ☐ Brown ☐ Hazel ☐Green ☐ Other: _____

What was your natural hair color at age 6? ☐ Black ☐ Blonde ☐ Dark Brown ☐ Light Brown ☐ Red ☐ Auburn ☐ Other: _____

What was your natural hair color at age 20? ☐ Black ☐ Blonde ☐ Dark Brown ☐ Light Brown ☐ Red ☐ Auburn ☐ Other: _____

Describe your natural skin tone/color: ☐ Black ☐ Blonde ☐ Dark Brown ☐ Light Brown ☐ Red ☐ Auburn ☐ Other: _____

How many freckles do you have? ☐ None ☐ Very Few ☐ Moderate ☐ Many ☐ Covered

Describe your usual skin reaction to sun exposure:
Usually burn with no tanning _____ Usually tan with no burning _____
Usually burn with little tanning _____ Always tan with no burning _____
Usually burn with some tanning _____ Neither burn nor tan _____

Have you ever had severe sunburn where your melanoma occurred? ☐ Yes ☐ No ☐ Do not remember

If yes, at what age? _____

Have you ever been told you have "Dysplastic Nevus Syndrome" or "Ugly Mole Syndrome?" ☐ Yes ☐ No

What is the highest level of formal education you have completed?
☐ Grammar School ☐ Jr. High School ☐ Sr. High School 9 10 11 12 ☐ College 1 2 3 4 ☐ Post Graduate 1 2 3 4

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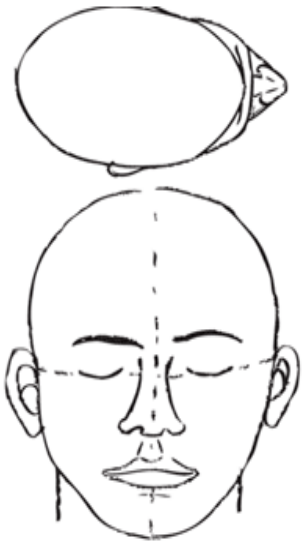
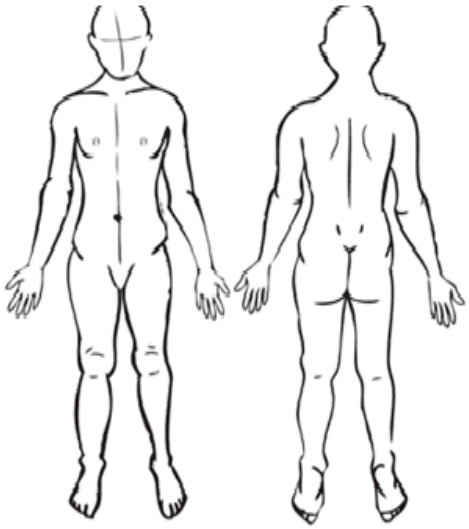
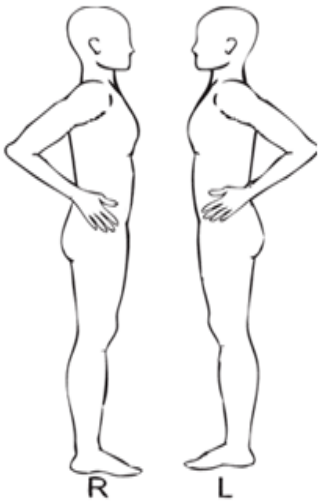
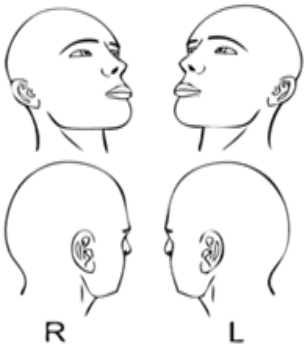
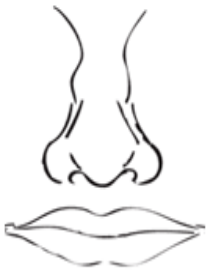
Please mark the location of your lesion or melanoma.

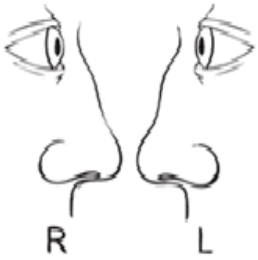


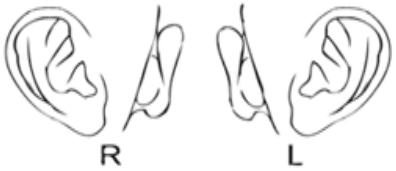


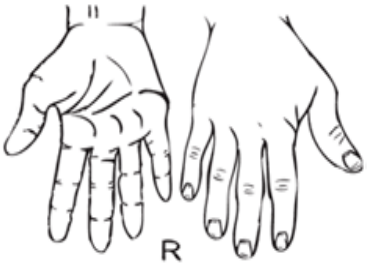


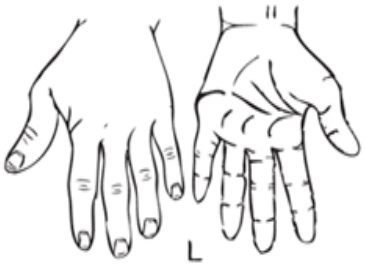


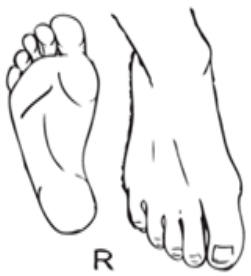


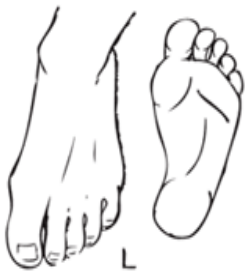












We would like to know how you selected the John Wayne Cancer Institute: **(Please check one)**

☐ Physician referred ☐ I asked my physician to refer me ☐ I referred myself

Friend or relative referred me: (other) _____

Have you or family members had a previous history of anesthesia problems? (Explain):

_____

_____

_____

History of your present health problem or illness for which you are seeking care at the John Wayne Cancer Center at Providence Saint John's Health Center:

Please describe briefly, in your own words, the date of onset of your current problem or illness, any symptoms you have experienced, and the dates of any tests and/or treatment(s), with the names and addresses of physicians whom you have consulted.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Please indicate if you have had or currently experiencing any of the following:
If you are not sure, please mark **"Do Not Know"** and we will assist you during your scheduled visit. **(Please check one)**

GENERAL

	CONDITION	YES	NO	DO NOT KNOW
1.	Swollen or enlarged (lymph) glands	☐	☐	☐
2.	Diabetes	☐	☐	☐
3.	Other tumors or cancers	☐	☐	☐
4.	Mumps	☐	☐	☐
5.	Rheumatic fever	☐	☐	☐
6.	Scarlet fever	☐	☐	☐
7.	Nervous disorders	☐	☐	☐
8.	Gallbladder disease	☐	☐	☐
9.	Venereal disease	☐	☐	☐
10.	Hepatitis	☐	☐	☐
11.	Cirrhosis	☐	☐	☐
12.	Epilepsy	☐	☐	☐
13.	Infectious disease	☐	☐	☐
14.	Personal or Family history of Anesthesia problems	☐	☐	☐
15.	Shortness of breath	☐	☐	☐

HEAD, EYES, EARS, NOSE & THROAT

	CONDITION	YES	NO	DO NOT KNOW
1.	Headaches	☐	☐	☐
2.	Dizziness or fainting spells	☐	☐	☐
3.	Eye Injuries	☐	☐	☐
4.	Double Vision	☐	☐	☐
5.	Blurred Vision	☐	☐	☐
6.	Eye Pain	☐	☐	☐
7.	Cataracts	☐	☐	☐
8.	Glaucoma	☐	☐	☐
9.	Earaches	☐	☐	☐
10.	Ringing or buzzing in ear	☐	☐	☐
11.	Decrease or loss of hearing	☐	☐	☐
12.	Sensation of spinning	☐	☐	☐
13.	Sinus Trouble	☐	☐	☐
14.	Nose Bleeds	☐	☐	☐
15.	Sore Tongue	☐	☐	☐
16.	Chipped /Loose teeth	☐	☐	☐
17.	Bleeding Gums	☐	☐	☐
18.	Dentures	☐	☐	☐
19.	Unusual trouble with teeth	☐	☐	☐
20.	Skin Tumors/removed moles or burned off	☐	☐	☐
21.	Chronic or frequent infections, colds	☐	☐	☐
22.	Skin Disease	☐	☐	☐

ENDOCRINE

	CONDITION	YES	NO	DO NOT KNOW
1.	Thyroid disorder or Goiter	☐	☐	☐
2.	Medication for thyroid or tests	☐	☐	☐
3.	Frequent Laryngitis	☐	☐	☐
4.	Hoarseness or change in voice	☐	☐	☐

BREAST

	CONDITION	YES	NO	DO NOT KNOW
1.	Breast lump(s)	☐	☐	☐
2.	Breast pain	☐	☐	☐
3.	Nipple discharge	☐	☐	☐

HEART

	CONDITION	YES	NO	DO NOT KNOW
1.	Heart disease	☐	☐	☐
2.	Bleeding disease or disorder	☐	☐	☐
3.	Hypertension (high blood pressure)	☐	☐	☐
4.	Pain or pressure in chest	☐	☐	☐
5.	Undue shortness of breath (day or night)	☐	☐	☐
6.	Ankle swelling	☐	☐	☐
7.	Pain in legs while walking	☐	☐	☐
8.	Fast or irregular heart beat (palpitations)	☐	☐	☐
9.	Heart murmurs	☐	☐	☐
10.	Implant device (shunt, pump or pacemaker)	☐	☐	☐

PULMONARY

	CONDITION	YES	NO	DO NOT KNOW
1.	Chronic cough, coughed up blood	☐	☐	☐
2.	Date of last Chest X-Ray (if any)	☐	☐	☐
3.	Soaking sweats	☐	☐	☐
4.	Exposure to tuberculosis (TB)	☐	☐	☐
5.	Asthma	☐	☐	☐

GASTROINTESTINAL

	CONDITION	YES	NO	DO NOT KNOW
1.	Chronic cough, coughed up blood	☐	☐	☐
2.	Recent gain or weight loss: Gain_____ Loss_____ (lbs)	☐	☐	☐
3.	Decreased appetite	☐	☐	☐
4.	Difficulty swallowing	☐	☐	☐
5.	Nausea or vomiting	☐	☐	☐
6.	Constipation	☐	☐	☐
7.	Frequent bowel movements	☐	☐	☐
8.	Recent change in bowel movements	☐	☐	☐
9.	Black bowel movement	☐	☐	☐
10.	Blood in stool	☐	☐	☐
11.	Jaundice	☐	☐	☐

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GENITOURINARY URINARY

	CONDITION	YES	NO	DO NOT KNOW
1.	Kidney trouble	☐	☐	☐
2.	Frequent or painful urination	☐	☐	☐
3.	Kidney stones	☐	☐	☐
4.	Blood in urine	☐	☐	☐
5.	Sugar or albumin in urine	☐	☐	☐
6.	Slow start of urine stream	☐	☐	☐
7.	Passing urine at night	☐	☐	☐

MUSCULOSKELETAL

	CONDITION	YES	NO	DO NOT KNOW
1.	Arthritis or rheumatism	☐	☐	☐
2.	Back or bone pain	☐	☐	☐
3.	Clumsiness/awkwardness s of hands, feet	☐	☐	☐
4.	Numbness or tingling of hands or feet	☐	☐	☐
5.	Muscle pain or weakness	☐	☐	☐

NEUROLOGIC

	CONDITION	YES	NO	DO NOT KNOW
1.	Forgetfulness	☐	☐	☐
2.	Reactions to serum, drug or medicine	☐	☐	☐
3.	Unusual fatigue	☐	☐	☐
4.	Excessive worry	☐	☐	☐
5.	Excessive depression	☐	☐	☐
6.	Nervous disorders	☐	☐	☐
7.	Sexual impotence	☐	☐	☐
8.	Seizures	☐	☐	☐
9.	Strokes	☐	☐	☐
10.	Trans ischemic attack (TIA)	☐	☐	☐

ALCOHOL CONSUMPTION

	Indicate next to each box the amount of drinks & Frequency – i.e. Daily, Weekly or Monthly	AMOUNT	NONE
1.	Beer		
2.	Wine		
3.	Whiskey		
4.	Other		

(Check one) SMOKING: ☐ Yes ☐ No CIGARETTES: ☐ Yes ☐ No Packs Per Day: _____

GYNECOLOGICAL (WOMEN ONLY)

	CONDITION	YES	NO	DO NOT KNOW
1.	Vaginal bleeding following intercourse	☐	☐	☐
2.	Painful menstruation	☐	☐	☐
3.	Irregular or excessive menstruation	☐	☐	☐
4.	Vaginal discharge	☐	☐	☐
5.	Been treated for female disorder	☐	☐	☐
6.	Have you used an intrauterine device	☐	☐	☐
7.	Menopause	☐	☐	☐

PLEASE LIST ANY PAST BREAST PROBLEMS (LIST)

Right/Left Side	Type of Problem	When

Age of menstruation:	Number of pregnancies:
Date of your last menstrual Cycle (LMC):	Number of births:
Interval between periods:	Number of miscarriages:
Date of last period:	Number of abortions:
Duration of periods:	Age at first child:
Family history of breast problems:	

Have you ever taken hormones? ☐ **Yes** ☐ **No** ☐ **Don't Know**

	When Started?	When Stopped?
Hormones		
Birth control pills		
Estrogen		
Tamoxifen		
Evista **(Raloxifene)**		
Arimidex		
Other: Specify		

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PAST SURGERIES (OPERATIONS) (please list in chronological order)

Date	Type of operation/procedure	Reason for Surgery	Hospital	Doctor

OTHER HOSPITALIZATIONS (please list in chronological order)

Date	Type	Hospital	Doctor

Radiation Therapy Treatment (We need to know when treatment started and completed, please list in chronological order)

Started		Stopped		Area of body Treated	Hospital	Doctor
Month	Year	Month	Year			

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List any medications you are now taking, date you started and discontinued: (including over the counter/non-prescription drugs {i.e. Aspirins, Tylenol, Vitamins, Diet Pills, etc.}.

	Name of Medication(s)	Dosage	Frequency	When Started	When Stopped
Pain Pills					
Vitamins/ Herbal Supplements					
Sleeping Pills					
Other					

Are you allergic to any medication? ☐ Yes ☐ No

Please list any medications to which you have had an allergic reaction, and the type of reaction(s):

	Name of Medication	Allergic Reaction(s)
1.		
2.		
3.		
4.		
5.		
6.		

FAMILY MEDICAL HISTORY

Relative	Age	State of Health	If Deceased- Cause of Death	Age at Death
Father				
Mother				
Spouse				
Brother(s)				
Sister(s)				
Children				
Grandparents				

Check (✓) if your blood relative has had any of the following:

✓	Disease	Relative
☐	Anemia	
☐	Bleeding tendency	
☐	Cancer	
☐	Breast	
☐	Ovarian	
☐	Colon	
☐	Prostate	
☐	Chronic Arthritis	
☐	Other: please specify	
☐	Asthma, hay fever, or other allergies	

✓	Disease	Relative
☐	Diabetes	
☐	Emphysema	
☐	Goiter	
☐	Heart Disease	
☐	High Blood Pressure	
☐	Kidney Disease	
☐	Leukemia	
☐	Tuberculosis	
☐	Any other Illness: specify	
☐	Nervous or mental condition	

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