PROVIDENCE
Saint John's
Health Center

John Wayne Cancer Institute

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

Medical Questionnaire

Date: _____

Name: _____ Gender: ☐ Male ☐ Female Age: _____
Last First Middle

Birth-date: _____ Birth Place: _____ Mother's Birth Name: _____

Social Security #: _____-_____-_____ Driver's License #: _____

Marital Status: ☐ Single ☐ Married – Spouse's Name _____

Married how long? _____ ☐ Divorced ☐ Separated ☐ Widowed

Language Spoken: _____ Interpreter Required? ☐ Yes ☐ No

Home Address: _____

City: _____ State: _____ Zip-code: _____-_____

Phone: _____ Fax: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip-code: _____-_____ Fax: _____

Emergency Contact: _____ Relationship: _____
(Not living in the same household)

Address: _____

City: _____ State: _____ Zip-code: _____ Fax: _____

Local Telephone Number: (Relative, Friend or Hotel) _____

1. Referring Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State: _____ Zip-code: _____-_____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

2. Other Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State: _____ Zip-code: _____-_____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

3. Other Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State: _____ Zip-code: _____-_____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

*** Periodic reports may be sent to your physician(s). Please check box of any physician you wish to receive reports.**

Patient Name: _____ Date of Birth:_____ Date: _____

Height:_____ Weight:_____ SS #: _____ - _____ - _____ Spouse's Name: _____

Allergies

Category	*Yes*	*No*	*Do Not Know*	*List Allergies*	*Explain Reaction*
Drugs	☐	☐	☐		
Food	☐	☐	☐		
Environmental	☐	☐	☐		

Medical History:

☐ Bleeding	☐ Dizziness / Fainting	☐ Infectious Disease	☐ Shortness of Breath
☐ Blood Disease	☐ Edema	☐ Kidney Disease	☐ Skin Condition
☐ Bone Disorder	☐ Gastrointestinal	☐ Mental Illness	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Pain	☐ Thyroid Disorder
☐ Chipped / Loose Teeth	☐ Hypertension	☐ Pulmonary Disease	☐ Personal History of Anesthesia problems
☐ Dentures	☐ Implanted Device (Shunt, Pump, Pacemaker)	☐ Seizures	☐ Family History of Anesthesia problems
☐ Diabetes	**For Women: Date of Last Menstrual Period (LMP):_____		

Please list and describe any previous Hospitalization and / or Surgeries:

_____

_____

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

_____

_____

Do you: Smoke: ☐ Yes ☐ No Amount:_____

Consume Alcohol: ☐ Yes ☐ No Amount:_____

Medications

	Name of Medication	Dose	Frequency	Last Dose	Comments
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Patient Name: _____

Please indicate if you have had or currently are experiencing any of the following. If you are not sure, please mark "Do Not Know" and we will be happy to assist you during your scheduled visit.

GENERAL

	Condition	Yes	No	Do Not Know
1.	Swollen or enlarged (lymph) glands	☐	☐	☐
2.	Diabetes	☐	☐	☐
3.	Other tumors or cancer	☐	☐	☐
4.	Mumps	☐	☐	☐
5.	Rheumatic fever	☐	☐	☐
6.	Scarlet fever	☐	☐	☐
7.	Nervous disorders	☐	☐	☐
8.	Gallbladder disease	☐	☐	☐
9.	Venereal disease	☐	☐	☐
10.	Hepatitis	☐	☐	☐
11.	Cirrhosis	☐	☐	☐
12.	Epilepsy	☐	☐	☐

HEAD, EYES, EARS, NOSE, THROAT – (HEENT)

	Condition	Yes	No	Do Not Know
1.	Headaches	☐	☐	☐
2.	Dizziness or fainting spells	☐	☐	☐
3.	Eye injuries	☐	☐	☐
4.	Double vision	☐	☐	☐
5.	Blurring vision	☐	☐	☐
6.	Eye pain	☐	☐	☐
7.	Cataracts	☐	☐	☐
8.	Glaucoma	☐	☐	☐
9.	Earaches	☐	☐	☐
10.	Ringing or buzzing in ear	☐	☐	☐
11.	Decrease / loss of hearing	☐	☐	☐
12.	Sensation of spinning	☐	☐	☐
13.	Sinus trouble	☐	☐	☐
14.	Nose bleeding	☐	☐	☐
15.	Sore tongue	☐	☐	☐
16.	Bleeding gums	☐	☐	☐
17.	Unusual trouble with teeth	☐	☐	☐
18.	Skin disease	☐	☐	☐
19.	Skin tumors / moles removed or burned	☐	☐	☐
20.	Chronic or frequent infections, colds	☐	☐	☐

Patient Name: _____

ENDOCRINE

	Condition	Yes	No	Do Not Know
1.	Thyroid trouble or goiter	☐	☐	☐
2.	Thyroid medication or tests	☐	☐	☐
3.	Frequent Laryngitis	☐	☐	☐
4.	Hoarseness or change in voice	☐	☐	☐

BREAST

	Condition	Yes	No	Do Not Know
1.	Lumps in breast	☐	☐	☐
2.	Pain in breast	☐	☐	☐
3.	Nipple discharge	☐	☐	☐

HEART

	Condition	Yes	No	Do Not Know
1.	Heart Disease	☐	☐	☐
2.	Bleeding tendency or easy bleeding	☐	☐	☐
3.	High Blood pressure	☐	☐	☐
4.	Pain or pressure in chest	☐	☐	☐
5.	Undue shortness in breath (day or night)	☐	☐	☐
6.	Ankle Swelling	☐	☐	☐
7.	Pain in legs while walking	☐	☐	☐
8.	Fast or irregular heart beating (palpitations)	☐	☐	☐
9.	Heart murmurs	☐	☐	☐

PULMONARY

	Condition	Yes	No	Do Not Know
1.	Chronic cough, coughed up blood	☐	☐	☐
2.	Do you have the date of your last chest x-ray?	☐	☐	☐
3.	Soaking sweats	☐	☐	☐
4.	Exposure to TB	☐	☐	☐
5.	Asthma	☐	☐	☐

Patient Name: _____

GASTROINTESTINAL

	Condition	Yes	No	Do Not Know
1.	Stomach, liver or intestinal trouble	☐	☐	☐
2.	Recent gain or loss of weight. (lbs.) Gain _____ Loss _____	☐	☐	☐
3.	Decreased appetite	☐	☐	☐
4.	Difficulty swallowing	☐	☐	☐
5.	Nausea or vomiting	☐	☐	☐
6.	Frequent bowel movements	☐	☐	☐
7.	Constipation	☐	☐	☐
8.	Recent change in bowel movements	☐	☐	☐
9.	Black bowel movements	☐	☐	☐
10.	Blood in stools	☐	☐	☐
11.	Jaundice	☐	☐	☐

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 starting 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 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	☐	☐	☐

Patient Name: _____

Women Only

GYNECOLOGICAL

	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.	Have you gone through menopause	☐	☐	☐

Please list any past breast problems:

_____

_____

_____

_____

_____

_____

Are you taking hormones: ☐ Yes ☐ No _____

Have you ever taken birth control pills or hormones? ☐ Yes ☐ No

Type: _____ How long? _____

When stopped? _____

Age of onset of menstruation: _____

Interval between periods: _____

Date of last period: _____

Number of pregnancies: _____

Number of births: _____

Number of abortions: _____

Your age at birth of your first child: _____

Family history of breast problems _____

_____

_____

_____

Date of your Last Menstrual Cycle (LMC): _____

Patient Name: _____

Past Surgeries (Operations):
Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Other Hospitalizations:
Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

Radiation Therapy Treatment:
Please list in chronological order.
We need to know when treatment started and when it was completed.

STARTED?		STOPPED?		AREA OF BODY TREATED	HOSPITAL	DOCTOR
Month	Year	Month	Year			

Patient Name: _____

Family History

RELATION	AGE	STATE OF HEALTH	IF DECEASED – CAUSE OF DEATH	AGE AT DEATH
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Patient Name: _____

Have any of your *blood* relatives, husband, wife or children had any of the following?

Yes	No	(CHECK EACH ITEM)	RELATION(S)
☐	☐	Tuberculosis	
☐	☐	Diabetes	
☐	☐	Cancer	
☐	☐	Leukemia	
☐	☐	Anemia	
☐	☐	Bleeding Tendency	
☐	☐	Heart Disease	
☐	☐	High Blood Pressure	
☐	☐	Kidney Disease	
☐	☐	Asthma, Hay Fever, Other Allergy	
☐	☐	Chronic Arthritis (Rheumatism)	
☐	☐	Nervous Or Mental Disorder	
☐	☐	Goiter	
☐	☐	Emphysema	
☐	☐	Any Other Illness	

Patient Name: _____

Billing Information

Billing Information: ☐ Self-Pay ☐ Insurance ☐ Other _____

Insurance Company 1. _____ Policy #: _____

Supplementary Ins. Co.: _____ Policy#: _____

Type of Insurance Coverage: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other _____

Insurance Company 2. _____ Supplementing: _____

Type of Insurance Coverage: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other _____

Name of Insured: _____ Social Security # of Insured: _____

If you are not the insured indicated above, your name: _____

We would like to know how you selected the John Wayne Cancer Institute:

☐ Physician referred; ☐ I asked my physician to refer me; ☐ I referred myself;
☐ A friend or relative referred me; ☐ Other: _____