

FEMALE PATIENT QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

REFERRING PHYSICIAN _____ PRIMARY CARE PROVIDER _____

Previous Cancers? Y N Type _____ Current status: Active Remission Cure Unknown

CHEMOTHERAPY? PRIOR CURRENT Where? _____ Managing doctor? _____

PREVIOUS RADIATION THERAPY? Y N Part of body? _____ Dates/facility _____

<u>PREVIOUS SURGERIES:</u>	TYPE OF SURGERY	Approximate Date	TYPE OF SURGERY	Approximate Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICAL HISTORY: Do you currently have or have history of (please check)
 Heart disease High blood pressure Scleroderma/Lupus Diabetes Thyroid problems Glaucoma Crohn's

OTHER ILLNESSES OR HOSPITALIZATIONS: _____

Major injury in the past? (describe) _____

HAVE YOU HAD ALLERGIES TO ANY OF THESE? Iodine IV dye Latex Adhesive

MEDICATION ALLERGIES / ADVERSE REACTION EXPERIENCED: None

Allergic to _____ Reaction _____ Allergic to _____ Reaction _____

Allergic to _____ Reaction _____ Allergic to _____ Reaction _____

ANY PROBLEMS WITH PAIN? Y N Where is your pain located? _____

Cause of your pain if known: Cancer Arthritis Recent Surgery Treatment Broken Bone Injury Unknown

Name and frequency of pain medications: _____ Pain Control: Good Fair Poor

Please list present health or cause of death, age, or age at death for family members:

Living (Yes or No)	Age	Health now (or cause of death)	History of cancer
Father: _____	_____	_____	_____
Mother: _____	_____	_____	_____
Spouse: _____	_____	_____	_____

Sisters: Number Alive: _____ Number Dead: _____ Cause of death: _____

Brothers: Number Alive: _____ Number Dead: _____ Cause of death: _____

Number Biological Children: _____ Ages and Health: _____

Other Family Members With Cancer _____

SOCIAL HISTORY:

Past Education: H/S Voc Tech College Post-Grad **Occupation** (Current or previous): _____

Retired Y N **Military Service?** Y N # of years _____

Regular Exercise: None Limited Moderate Strenuous Hrs per week: _____

Prior exposure : Asbestos Radiation Toxic Chemicals/Metals Textile Industry Rock Dust Insecticides None

Continued exposure? Y N

Marital Status: Single Married ___# of yrs Divorced Separated Widowed

Live alone? Y N Who lives with you? _____

Have you ever smoked cigarettes? Y N Age started: _____ Avg. # packs per day: _____ If stopped, age: _____

2nd hand smoke exposure? Y N Current Past List other tobacco products used _____

Do you drink alcohol? Y N If yes, average # drinks/day: _____ Age started: _____ If stopped, age: _____

Do you have concerns about transportation for radiation treatments? Y N Who can drive you? _____

REVIEW OF SYSTEMS: Place a ✓ by any of the following that you have/had a history of:

GENERAL

- Loss of weight (___ lbs in last 3 mos)
Cause: _____
- Loss of energy
- Frequent fatigue
- Soaking night sweats
- Fever (_____ ° F)

EYES/EARS/NOSE/THROAT

- Glasses (Last exam _____)
- Glaucoma
- Cataracts Right Left
- Blindness Right Left
- Hearing problems (Describe):

- Ringing in ears
- Wearing hearing aids
- Dental problems
- Dentures Partial Full
- Dizziness
- Nasal problems _____
- Voice hoarseness/cause _____
- Problems swallowing

CARDIOVASCULAR

- Heart arrhythmia (♥ Race / skip beats?)
- Hypertension/High blood pressure
- Chest pain/Angina
- Cardiologist DR. _____
- Feet/ankle swelling (unrelated to position)
- Prior heart attack/bypass surgery
- Pacemaker

RESPIRATORY

- Coughed up blood in last 3 months
- Cough Chronic New onset
- Cigarette cough
- Asthma
- Emphysema
- Chronic Bronchitis
- Oxygen # liters _____
- Shortness of breath
 - With walking
 - With exertion
- Worse Better Chronic

ALLERGIES

- None Drugs Food
- Dust Animals Hay fever

GASTROINTESTINAL

- Antacids
- Laxatives
- Abdominal pain
- Constipation
- Rectal pain
- Decreased stool caliber
- Change in stool color
- Liver disease/Hepatitis
- Diverticulitis
- Colon polyps
- Reflux Disease/GERD
- Inflammatory bowel disease
- Last colonoscopy _____
- GI tract bleeding
- Jaundice
- Diarrhea
- Nausea/Vomiting

GENITOURINARY

- Kidney problems
- Blood in urine
- Burning on urination
- Difficulty urinating
- Nighttime urination (# _____)
- Decreased stream
- Incontinence (pads/day _____)
- Menopause (Age _____)
- Vaginal bleeding
- Hysterectomy for _____
- Ovaries removed
- Hormone replacement Rx (# years _____)
Type _____

- Number of pregnancies _____
- Number of live births _____
- Age at first delivery _____
- Birth control (# years) _____
Type _____
When stopped _____

BREAST

- Nipple retraction
- Nipple discharge
- Lump
- Skin dimpling
- Infection
- Prior biopsy
- Last mammogram _____

MUSCULOSKELETAL

- Arthritis
- Joint pains
- Stiff joints
- Muscle weakness
- Chronic back pain
- New skeletal pain/where _____
Cause _____

MOBILITY

- Normal activity
- Limited work
- Can not work
- Limited self-care
- Require assistance
- Wheelchair bound
- Bedridden

NEUROLOGICAL

- Memory Loss
- Passing out
- Seizures
- Paralysis (short/long-term)
- Tremors
- Difficulty walking
- Dizziness
- ↑ Headache Recent Chronic
- Depression
Treatment _____
- Suicidal
- Insomnia Recent Chronic

ENDO/HEME/LYMPH

- Heat intolerance
- Cold intolerance
- Anemia
- Easy bleeding
- Easy bruising
- Blood transfusion reaction
- Enlarged lymph nodes

SKIN

- Skin cancer in the past
- Sunburn history
- Sunburn easily
- Tanning history (Sun/Booth)
- Bleeding/Enlarging skin
- Moles changing color
- Severe skin burn in past

