

# MALE 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: \_\_\_\_\_

2<sup>nd</sup> 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

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 \_\_\_\_\_)
- Prostatitis
- Prostatectomy
- ↑ PSA
- Hormone treatment  
Type \_\_\_\_\_
- Testosterone supplements

BREAST/SKIN

- Breast problems  
Describe \_\_\_\_\_
- Skin cancer in the past
- Sunburn history
- Tanning history (Sun/Booth)
- Bleeding/Enlarging skin
- Moles changing color
- Severe skin burn in past

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

ALLERGIES

- None
- Drugs
- Food
- Dust
- Animals
- Hay fever

