

MALE PATIENT QUESTIONNAIRE

NAME _____ DOB _____ AGE _____ DATE _____

REFERRING PHYSICIAN _____ REFERRAL DATE _____ PRIMARY PROVIDER _____

Current Cancer Type _____

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

Recent immunizations: Circle all that apply Flu vaccine Shingles Pneumonia HPV H1N1 Date received _____

PREVIOUS SURGERIES: TYPE OF SURGERY Approximate Date TYPE OF SURGERY Approximate Date

PRIOR HOSPITALIZATIONS/OTHER ILLNESSES/PAST INJURIES: (Describe) _____

CHEMOTHERAPY? PRIOR CURRENT Where? _____ Managing doctor? _____

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

HORMONAL THERAPY? Y N Type _____

MEDICAL HISTORY: Do you currently have or have history of (please check)

Lupus Mental Health Issues Scleroderma Collagen Vascular Disease High Blood Pressure Diabetes

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 _____

Name and location of preferred pharmacy _____

ANY PROBLEMS WITH PAIN? Y N Where is your pain located? _____ Rate of Pain 0-10 _____

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

FAMILY HISTORY: 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) Any history of cancer?

Spouse: _____

Number of Biological Children: _____ Ages and Health: _____

Father: _____

Mother: _____

Brothers: Number Alive: _____ Number Dead: _____ Cause of death: _____ History of cancer? _____

Sisters: Number Alive: _____ Number Dead: _____ Cause of death: _____ History of cancer? _____

Other Family Members With Cancer: (relationship and type of cancer) _____

SOCIAL HISTORY:

Past Education: H/S Voc Tech College # of years _____ Post-Grad Degree Current Student

Retired Y N Military Service? Y N # of years _____ Primary Type of Work (Current or previous): _____

Current Work: FT PT On disability On medical leave Unemployed

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

Hazardous exposure: None Asbestos Radioactive Materials Toxic Chemicals/Metals Textile Industry
 Rock Dust or Wood Commercial Insecticides Oil or Chemical Industry Continued exposure? Y N

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

Live alone? Y N Who lives with you? _____

Any history of substance use: Cocaine Heroin Marijuana Prescription Pain Meds

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

2nd hand smoke exposure? Y N Current Past Where did exposure occur? Home Work Socially

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? _____

Do you have DNR (Do Not Resuscitate) or POLST (Physician Orders for Life Sustaining Treatment) orders in place? Y N If yes, please bring a copy with you to your consultation.

Did anyone recommend this facility to you (please check all that apply)? Physician Family Friend Other: _____ None

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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 months)
- Energy level Normal Less Better
- Fatigue None Mild
 Moderate Extreme
- Difficulty going asleep
- Difficulty staying asleep

EYES/EARS/NOSE/THROAT

- Glasses (Last exam _____)
- Glaucoma
- Cataracts Right Left
- Blindness Right Left
- Excess tearing/Double vision/Blurry vision
- Hearing problems (Describe):

- Ringing in ears/Buzzing in ears
- Wearing hearing aids Rt Lt
- Dizziness
- Nasal problems
- Dental problems
- Dentures Partial Full
- Problems chewing or eating
- Problems swallowing
- Voice hoarseness/cause _____

CARDIOVASCULAR

- Heart rate irregular/fast/racing/skip beats
- Heart problems/High blood pressure/CAD
- Prior heart attack/bypass surgery
When? _____
- Stroke
- Chest pain/Angina
- Pacemaker
- Feet/ankle swelling (unrelated to position)
- Cardiologist DR. _____

RESPIRATORY

- Shortness of breath
 With walking With exertion
 Mild Moderate Severe
- Cough Chronic New onset
Do you use cough medicine? Y N
- Coughed up blood in last 3 months
- Asthma/Emphysema/COPD
- Oxygen # liters _____
- Cigarette cough
- Chronic Bronchitis
- Sleep apnea

GASTROINTESTINAL

- Nausea/Vomiting/Vomiting Blood
- Loss of appetite
- Reflux Disease/Heartburn/GERD
Meds _____
- Jaundice
- Diarrhea Meds _____
- Constipation Meds _____
- Pain in abdomen
- Rectal pain
- Change in stool size/stool color
- Blood in stools or black stools
- Bowel incontinence
- Last colonoscopy _____
 Results normal Results abnormal
- Liver disease/Hepatitis
- Diverticulitis
- Colon/intestinal polyps
- Inflammatory or irritable bowel disease
- GI tract bleeding
- Hemorrhoids
- Stomach ulcers
- Colostomy/ileostomy

GENITOURINARY

- Prostatitis
- Prostatectomy
- ↑ PSA Date of last PSA _____
- Hormone replacement
Type _____
- Testosterone supplements
- Bladder empties fully
- Urinary frequency/urgency
- Incontinence (# pads/day _____)
- Nighttime urination (# times _____)
- Burning on urination
- Blood in urine
- Decreased stream
- Vasectomy

BREAST/SKIN

- Breast problems
Describe _____
- Sunburn easily
- Bad sunburn in past
- Tanning history (sun/booth)
- Skin cancer in the past
- Bleeding/enlarging skin sores

- Moles changing color

MUSCULOSKELETAL

- Arthritis Where? _____
- Joint pains Where? _____
- Stiff joints Where? _____
- Muscle weakness Where? _____
- Chronic back pain
- New skeletal pain
Where? _____
Cause? _____
- Fibromyalgia

MOBILITY

- Normal activity
- Balance problems
- Limited work
- Cannot work
- Limited self-care/ requires assistance
- Wheelchair bound/bedridden
- Use walker/cane/crutches
- Difficulty moving any extremity

NEUROLOGICAL

- ↑ Headache Recent Chronic
- Paralysis
- Tingling/numbness
- Seizures Frequency _____
- Dizziness/vertigo
- Passing out
- Memory Loss
- Difficulty walking
- Tremors
- Depression/Anxiety
Treatment _____
- Suicidal

ENDO/HEME/LYMPH

- Heat/cold intolerance
- Anemia
- Easy bleeding
- Easy bruising
- Blood transfusion reaction
- Enlarged lymph nodes
- Soaking night sweats
- Fever (_____ °F)
- Lymphedema
- History of diabetes
- History of thyroid problems

