# MEDICAL HISTORY QUESTIONNAIRE

Head and Neck Oncologic Surgery

Room #

What are you being seen for? _____

PATIENT LABEL

How long have you had this problem? _____

Who is your referring physician? _____

Please list other physicians that you would like a report sent to regarding your visit _____

**PAST MEDICAL HISTORY**

| PLEASE LIST ALL CURRENT MEDICAL PROBLEMS | PLEASE LIST ALL SURGERIES (YEAR) | ******* FOR CLINIC USE ******** |
|---|---|---|
| _____ | _____ | WT_____ MRSA+ Y N |
| _____ | _____ | BP_____ VRE + Y N |
| _____ | _____ | PULSE_____ HEIGHT |
| _____ | _____ | TEMP_____ _____ |
| _____ | _____ | **DENTAL** |
| _____ | _____ | teeth yes no |
| _____ | _____ | dentures yes no |
| _____ | _____ | full set upper lower both |
| _____ | _____ | partials upper lower both |

Have you previously received chemotherapy? If yes, Diagnosis _____ year _____
facility_____ city/state_____ Treating Physician_____

Have you previously received radiation therapy? If yes, Diagnosis _____ year _____
facility _____ city/state_____ Treating Physician _____

## MEDICATIONS

PLEASE LIST **ALL** CURRENT MEDICATION
**Including:** prescription, over the counter, birth control, vitamins, etc.

| MEDICATION | DOSE / FREQUENCY |
|---|---|
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |

## ALLERGIES

PLEASE LIST **ALL** MEDICATION / FOOD ALLERGIES
DO YOU HAVE A **LATEX** ALLERGY? YES ___ NO ___

| MEDICATION / FOOD | REACTION |
|---|---|
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |

**PHARMACY**_____ CITY, STATE _____ PHONE # _____

**Please complete back of form**

**SOCIAL HISTORY** This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

What type of work do you do? _____

Do you use tobacco products ? No ___ When did you quit _____ Yes ___ Type / amount / how long : _____
Do you drink alcohol ? No ___ When did you quit _____ Yes ___ Type / amount / how long : _____
Do you use illegal drugs ? No ___ When did you quit _____ Yes ___ Type / amount / how long : _____

Have you been exposed to or tested positive for Yes/No: Human Papilloma Virus ( HPV ) ___ Gonorrhea ___ HIV __ Hepatitis __ A / B / C
Do you have implants, such as artificial heart valves or hip prosthesis? YES ___ NO ___
Have you ever been told to take antibiotics, prior to surgery, because of a heart condition? YES ___ NO ___

**REVIEW OF SYSTEMS**- Do you have any problems in the following areas. Please circle Yes (Y) or No (N) and underline one that applies.

**Constitutional**
Night sweats Y N
Recurrent fevers Y N
Your weight 1 month ago _____ lbs
Your weight 6 months ago _____ lbs

**Eyes**
Double vision Y N
Injuries Y N
Dryness Y N
Wear glasses or contacts Y N

**Ears, Nose, Mouth, Throat**
Sinus Congestion Y N
Runny or Bloody nose Y N
Post-Nasal Drip Y N
Hearing Loss Y N
Dry Throat / Mouth Y N
Difficulty / Pain with eating Y N

**Nutrition / Food Intake**
I can eat anything without difficulty Y
I can eat hard & crunchy foods Y N
I only eat soft foods Y N
I drink liquids, very little solid food Y N
I only drink liquids, no solid food Y N

**Cardiovascular**
Chest pain or angina Y N
Heart murmur Y N
Vascular Disease Y N

**Respiratory**
Asthma Y N
Chronic cough Y N
Shortness of Breath Y N
Bloody Sputum Y N

**Musculoskeletal**
Muscle pain / weakness Y N
Joint Pain Y N

**Gastrointestinal**
Constipation / Diarrhea Y N
Chronic nausea / vomiting Y N
Abdominal pain Y N

**Genitourinary**
Blood in urine Y N
Difficulty urinating Y N

**Neurologic**
Fainting spells or blacking out Y N
Difficulty with your speech Y N
Frequent headaches or migraines Y N
Seizures Y N

**Psychiatric**
Anxiety Y N
Depression Y N
Feeling suicidal Y N
Other psychiatric issues or treatment ?
_____

**Endocrine**
Hormone problems Y N
Pregnant or nursing Y N

**Integumentary**
Skin cancer Y N
Skin disease Y N

**Lymphatic / Hematologic**
Anemia Y N
Bleeding problems Y N
Persistent swollen glands/nodes Y N
Blood transfusions (when_____) Y N

**FAMILY HISTORY** (**Parents, Grandparents, Siblings, Children; Living or Deceased)** Please note for the following medical conditions:

| | | | |
|---|---|---|---|
| Arthritis | Asthma | Strokes / TIAs | Birth Defects |
| Diabetes | Pulmonary Disease | Migraines | Immune Disorders |
| High Blood Pressure | Thyroid Disease | Bleeding Disorders | Kidney Disease |
| Heart Disease/ Attacks | Tuberculosis | Problems with anesthesia | Hearing Impairment |

Cancer – type _____
Other-explain _____

Signature of patient _____ Date _____

If other person completing this form: Name_____ Relationship to patient_____
**********
FOR CLINIC USE ONLY _____

_____

_____

_____

_____

_____

_____

Medical staff reviewing Nursing staff