Peninsula cancer center

19917 Seventh Avenue, Suite 100
Poulsbo, WA 98370
(360) 697-8000
www.peninsulacancercenter.com

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ DOB: _______________

Height: _______ Weight: ________ Referring Physician: ______________________________

Primary Care Physician: _______________ Other Providers to Receive Copies: ________________

Allergies: (Drugs, Iodine, IV dye/contrast, seafood, latex, adhesive?) _________________________

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Medications & Dosage: (Include aspirin, supplements, diet & birth control pills. May attach separate list)

________________________ ______________________ ____________________

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Do you have the following: (If yes, please provide a copy for our records.)

Advance Directive ☐ Yes ☐No Living Will ☐ Yes ☐No Durable Power of Attorney ☐ Yes ☐No

LIFESTYLE				
☐Alcohol _____ oz. per week	☐Coffee/Tea/Cola _____ oz. per day	☐Smoking _____ cig per day______ # years ______ year quit ________	☐ Exercise _____ days per wk	☐ Recreational drugs
HEALTH MAINTENANCE	**Vaccinations/year of last:**	☐Influenza (Flu) ☐Pneumonia ☐Shingles		
	Test/Exam/year of last:	☐Colonoscopy	☐Complete Physical	

DO YOU EXPERIENCE THE FOLLOWING SYMPTOMS?				
General:	☐ weight change	☐ heat/cold intolerance	☐ night sweats/fevers	☐ fatigue
Skin:	☐ yellow/jaundice skin	☐ change in hair/nails	☐ moles/sunspots/bruises	
Eyes/Nose/Mouth:	☐ vision changes ☐ sore throat	☐ sores/blisters ☐ hoarseness	☐ sinus problems ☐ nose bleeds	☐ pain or difficulty swallowing
Chest	☐ coughing (phlegm/blood)	☐ wheezing/ shortness of breath	☐ chest pain/pressure	☐ irregular heart beat/ palpitations
Breast:	☐ lump/pain	☐ nipple discharge	☐ swollen lymph nodes	☐ skin changes
Abdomen:	☐ appetite loss ☐ diarrhea ☐ nausea/vomiting	☐ pain/cramping ☐ constipation	☐ bloating/belching/gas ☐ bloody stools	☐ heartburn ☐ change in stools
Urinary:	☐ voiding small/large amounts	☐ decreased force of stream	☐ pain, burning, frequency	☐ blood in urine ☐ incontinence
Arms/Legs/Back:	☐ muscle cramps/ weakness	☐ blue fingers/toes	☐ pain/swelling/numbness	
Nervous System:	☐ dizziness/fainting	☐ anxiety/depression	☐ insomnia/excessive snoring	☐ seizures

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MEDICAL HISTORY				
☐ Prior radiation treatments: When:		Where:		Reason:
☐ Cancer	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Anemia	☐ Diverticulosis
☐ Diabetes	☐ Atrial Fibrillation	☐ Heart Attack	☐ Rheumatic Fever	☐ COPD (Emphysema)
☐ Hepatitis	☐ Spleen Problems	☐ Firbromyalgia	☐ Kidney Problems	☐ Gallbladder Problems
☐ Skin Cancer	☐ Colonic Polyps	☐ Asthma	☐ Hernias	☐ Hemorrhoids
☐ Scleroderma	☐ Prostate Disease	☐ Hiatal Hernia	☐ Stomach Ulcers	☐ Uterus Problems
☐ High Blood Pressure	☐ Ovarian Problems	☐ Neurologic Problems	☐ Psychiatric Problems	☐ Hemophilia
☐ Stroke	☐ Pneumonia	☐Appendicitis	☐ Thyroid Problems	☐ Sleep Apnea
☐ Crohn's Disease	☐ Blood Clots (DVT or PE)	☐ Sexually Transmitted Diseases	☐ Congestive Heart Failure	☐ Irritable Bowel Syndrome
☐ Ulcerative Colitis	☐ Arthritis	☐ Acid Reflux	☐ Hazards Exposure To what:	☐ MRSA

FEMALE HEALTH HISTORY (Females only)		
Menstrual flow:	Number of:	☐ Menopause /Age at onset:
☐ Regulars ☐ Irregular ☐ Pain/Cramps	Pregnancies:________ Abortions:_______	Date of last PAP test:
Days of flow :	Miscarriages:________ Live births:_______	☐ Normal ☐ Abnormal
First day of last period:	Birth control method:	Date of last mammogram:
☐ Pain/bleeding during or after sex	Name of birth control pill:	☐ Normal ☐ Abnormal

SURGICAL HISTORY Do you have any implanted artificial devices?			
☐ Stent	☐ Heart Valve Replacement	☐ Defibrillator	☐ Pacemaker
☐ Cochlear implant	☐ Port-a-Cath	☐ Joint Replacement	
List All Surgeries (include date, reason and doctor)			

FAMILY HISTORY If a ***blood*** *relative* has suffered any of the following—please check the box and indicate which relative.				☐ Hypertension	
☐ Epilepsy		☐ Mental illness		☐ Glaucoma	
☐ Diabetes		☐ Hay fever		☐ Asthma	
☐ Anemia		☐ Arthritis		☐ Heart disease	
☐ Stroke		☐ Lipid disorder		☐ Alcoholism	
☐ Hepatitis		☐ Aneurysm		☐ Osteoporosis	
☐ Breast Cancer		☐ Thyroid disease		☐ Migraine	
☐ Prostate Cancer		☐ Ovarian Cancer		☐ Any Cancer at age 50 or under	
If history of cancer, please enter family member and type of cancer. If unknown, please state "unknown".					
Are you interested in genetic testing?		☐ Yes ☐ No ☐ I'd like more information			

Patient Signature ____ Date ____________________

Reviewing Provider Signature ________________________________ Date ____________________