CANCER INSTITUTE OF DALLAS
NEW PATIENT HEALTH QUESTIONNAIRE

Name: Date:

Referring Physician: Phone:

What is your main reason for coming to the doctor? _____

How long have you had this problem? _____ months _____ years

A REVIEW OF YOUR SYSTEMS

GENERAL SYPMPTOMS

Do you feel weak or tired?	☐ yes	☐ no	
Have you lost your appetite?	If yes, how long? _____	☐ yes	☐ no
Have you lost weight?	If yes, how much? _____	☐ yes	☐ no
Was your weight loss intentional?	☐ yes	☐ no	
Do you run an above normal temperature?	☐ yes	☐ no	
Have you noticed any swelling anywhere?	☐ yes	☐ no	
If yes, where? _____			
Do your feet or ankles swell?	☐ yes	☐ no	

HEAD, EYES, EARS, NOSE, THROAT

Do you have headaches?	☐ yes	☐ no
Do you have "sinus trouble"/symptoms?	☐ yes	☐ no
Have you been hoarse lately?	☐ yes	☐ no
Do you have trouble with your vision?	☐ yes	☐ no
Do you have trouble hearing?	☐ yes	☐ no

CHEST

Do you have a cough?	☐ yes	☐ no
Have you ever coughed up blood?	☐ yes	☐ no
Are you short of breath?	☐ yes	☐ no
Does your chest wall hurt?	☐ yes	☐ no

DIGESTION / STOMACH

Do you have trouble swallowing?	☐ yes	☐ no
Do you vomit? If yes, when? _____	☐ yes	☐ no
Do you have stomach pain?	☐ yes	☐ no
Do you have frequent constipation?	☐ yes	☐ no
Do you take laxatives or enemas for constipation? If yes, how often? _____	☐ yes	☐ no
Do you have loose bowels or diarrhea?	☐ yes	☐ no
Do you pass blood from your rectum?	☐ yes	☐ no
Do you ever have black or "tarry" stools?	☐ yes	☐ no
Have you ever had a flexible sigmoidoscopy or colonoscopy?	☐ yes	☐ no
If yes, where? _____		

GENITO / URINARY

Do you have trouble passing urine?	☐ yes	☐ no
Do you have burning or pain when urinating?	☐ yes	☐ no
Have you recently has an infection, blood or pus, in your urine?	☐ yes	☐ no
MALES OVER 50: Have you had a prostate exam?	☐ yes	☐ no

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BONES, JOINTS, MUSCLES

Do you have any back pain? ☐ yes ☐ no
Do you have joint pain? ☐ yes ☐ no

NERVES -- NERVOUS SYSTEM

Do you have weakness in your arms or legs? ☐ yes ☐ no
Do you have numbness or tingling in your hands or feet? ☐ yes ☐ no

MENSTRUAL HISTORY -- (for women only)

How many times have you been pregnant? _____
Have you ever had a miscarriage? If yes, how many? _____ ☐ yes ☐ no
When was your last menstrual period? _____ Yrs _____ Mon ☐ Unk
Are/were your menstrual periods irregular? ☐ yes ☐ no
Do/ did you menstruate too heavily? ☐ yes ☐ no
If you have stopped having menstrual periods at what age did you stop: _____ yrs old _____ yrs old
Do you have any menopausal symptoms? If yes, describe below. ☐ yes ☐ no

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Are you on birth control pills or hormone replacement therapy? ☐ yes ☐ no
Have you had a vaginal examination and "PAP" smear in the last year? ☐ yes ☐ no
Have you ever had a breast x-ray? (mammogram) ☐ yes ☐ no

PAST HISTORY

List operations, if any: Date

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Have you had any previous blood transfusions? If yes, when? _____ ☐ yes ☐ no

Do you have or have you had any of the following conditions?

Bronchial or lung trouble	describe: _____	☐ yes	☐ no
Tumor, growth or cancer	describe: _____	☐ yes	☐ no
Heart trouble	describe: _____	☐ yes	☐ no
Diabetes	describe: _____	☐ yes	☐ no
Stroke or convulsions	describe: _____	☐ yes	☐ no
Gall bladder trouble	describe: _____	☐ yes	☐ no
Stomach ulcers	describe: _____	☐ yes	☐ no
Jaundice or hepatitis	describe: _____	☐ yes	☐ no
Prostate trouble	describe: _____	☐ yes	☐ no
Kidney or bladder trouble	describe: _____	☐ yes	☐ no
Other - describe_____	describe: _____	☐ yes	☐ no
Other - describe_____	describe: _____	☐ yes	☐ no
Other - describe_____	describe: _____	☐ yes	☐ no
Other - describe_____	describe: _____	☐ yes	☐ no

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FAMILY HISTORY

Is your father living? If no, age at death _____ Cause_____ ☐ yes ☐ no
Current Age, if living? _____ Health status: _____
Is your mother living? If no, age at death _____ Cause_____ ☐ yes ☐ no
Current Age, if living? _____ Health status: _____
Do you have brothers? If yes, what is their general health?_____ ☐ yes ☐ no
Cause of death of any brothers not living? _____
Do you have sisters? If yes, what is their general health? _____ ☐ yes ☐ no
Cause of death of any sisters not living? _____
Are you married now? ☐ yes ☐ no
Do you have children? If yes, what is their general health?_____ ☐ yes ☐ no
What are their ages? _____
Are all your children living? If no, at what was their age at the time of death and the cause?

Is there any history of cancer in your family? Describe: _____

PERSONAL HISTORY

Do you smoke or have you ever smoked? ☐ yes ☐ no
Number per day: Cigarettes? _____ Cigars? _____ Pipe? _____
Do you drink coffee? If yes, number of cups per day? _____ ☐ yes ☐ no
Do you drink beer, wine, liquor? ☐ yes ☐ no
Number of drinks per: _____ per day? _____ per week?
Has drinking ever been a problem? ☐ yes ☐ no
Have you ever had a drug problem or are you using drugs now? ☐ yes ☐ no
Are you exposed to any chemical on your job? ☐ yes ☐ no
What type of work do you do? _____

FATIGUE SELF-ASSESSMENT

How would you rate your fatigue on a scale of 1 - 10 over the past 7 days? ____

1 = no fatigue carrying out normal activities, 10 = extreme fatigue -- difficulty getting out of bed

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MEDICATIONS AND ALLERGIES

Are you taking any medicines? ☐ yes ☐ no

List all medications:	Dose	Frequency	Reason for Taking

Do you take any natural/herbal, over the counter medicines or vitamins? ☐ yes ☐ no

List all medications:	Dose	Frequency	Reason for Taking

Are you allergic to any medication? If yes, list below and indicate the reaction ☐ yes ☐ no

List all medications:	Reaction

Patient Signature Date

If someone other than the patient completed this form, please give the name and relationship

Name: _____ Relationship:_____

DO NOT WRITE BELOW THIS LINE -- FOR DALLAS ONCOLOGY USE ONLY

History information reviewed during visit by Dr. _____ on _____
Physician printed name Date

Physician signature