# HEALTH HISTORY QUESTIONNAIRE

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Where information is filled in, please confirm it is correct.**

| NAME | SEX | BIRTHDATE/AGE | CONSULTATION DATE |
|---|---|---|---|
| | M ❑ F ❑ | | |
| **ADDRESS** | | **Phone** | **Contact** |
| | | | |

**REFERRING PHYSICIANS (please add all doctors that you would like us to be in contact with)**

**Referral Doctor**:

**Primary Care doctor:**

**Other doctors (and type):**

**How did you decide to see us? (check all):** ❑My Referring Doctor ❑Another Doctor :_____
❑Friend or Neighbor ❑Heard Radio Ad ❑ Saw Print Ad (where: _____) ❑ Web Search
Have you visited our website? ❑ Y ❑ N Any comments on site?:

**DIAGNOSIS or REASON FOR TODAY'S VISIT**

**WHEN DIAGNOSED, HOW DIAGNOSED, FIRST SYMPTOMS**

**WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE/HAVE YOU HAD?**

| PROBLEM | YES | NO | Doctor treated? YES | Doctor treated? NO | Details (include approximate date of diagnosis, at least) |
|---|---|---|---|---|---|
| AIDS/HIV positive | | | | | |
| Alzheimer's | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| Back problems | | | | | |
| Blood transfusions | | | | | |
| Bone loss (osteoporosis) | | | | | |
| Crohn's disease or ulcerative colitis | | | | | |
| Cancer (other than why you are here) | | | | | |

| PROBLEM (cont.) | YES | NO | Doctor treated? YES | NO | Details (include approximate date of diagnosis, at least) |
|---|---|---|---|---|---|
| Cardiac disease or other heart | | | | | |
| Diabetes | | | | | |
| Emphysema or lung problems | | | | | |
| Lupus or scleroderma | | | | | |
| Gallstones | | | | | |
| GERD (reflux, heartburn) | | | | | |
| Hepatitis | | | | | |
| High cholesterol | | | | | |
| High blood pressure | | | | | |
| Hypothyroid or hyperthyroid | | | | | |
| Impotence or infertility | | | | | |
| Kidney disorders or stones | | | | | |
| History of mononucleosis? | | | | | |
| Depression or mental illness | | | | | |
| Stroke or TIAs | | | | | |

| PRIOR ROUTINE TESTS: | YES | NO | |
|---|---|---|---|
| Do you receive regular mammograms? | | | Date of last mammogram: |
| Do you receive regular Pap smears? | | | Date of last Pap smear: |
| Do you have regular PSA checks? | | | Date of last PSA: |
| Do you have a pacemaker/defibrillator? | | | Date of your last physical exam: |

**LIST ALL MAJOR SURGERIES (provide details, including approximate dates)**

**EXTENDED HOSPITALIZATIONS (stays in the hospital for more than 48 hours—provide details)**

| **HAVE YOU EVER HAD RADIATION THERAPY TREATMENTS BEFORE?** | **YES ❑ NO ❑** | **IF YES, what part of your body, and what dates: _____** |
|---|---|---|

| **OBSTETRIC HISTORY (females only)** | | |
|---|---|---|
| Number of times pregnant: | Number of children with which you've been pregnant: | |
| Premature births: | Abortions (spontaneous or other): | Living children: |

**MEDICATION HISTORY:**
**list ALL medications you are now taking, including vitamins and over counter**

| | Name of drug | Strength | Taking for what problem: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**HORMONE THERAPY:**

Are you receiving hormone therapy? No ❑ Yes ❑ Name of medication: _____
Date therapy started: _____

**CHEMOTHERAPY HISTORY:**

Have you received, or are you currently receiving, chemotherapy treatments? Yes ❑ No ❑

| | Chemotherapy name | Number of cycles/cycle frequency | Date started | Date finished |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Have you met with a chemotherapy doctor yet? No ❑ Yes ❑, Name of doctor: _____

Has he/she scheduled you to start chemotherapy? No ❑ Yes ❑, Date scheduled to start: _____

**ALLERGIES: to MEDICATIONS or other?**

❑ I am NOT allergic to any medications

❑ I am allergic to the following medications: (List medications & reaction that you get, i.e. rash, fainting, etc.)

1.
2.
3.

| | | |
|---|---|---|
| Have you ever had anesthesia? | No ❑ | Yes ❑, Explain: |
| Anyone in your family ever had problems with anesthesia? | No ❑ | Yes ❑, Explain: |
| Have you ever received intravenous contrast? | No ❑ | Yes ❑, Explain: |
| If you received IV contrast, did you have any problems? | No ❑ | Yes ❑, Explain: |
| Do you have any seafood allergies? | No ❑ | Yes ❑, Explain: |
| Do you have other allergies? | No ❑ | Yes ❑, Explain: |

## FAMILY HISTORY

| | |
|---|---|
| MOTHER<br>❑ living ❑ deceased (at age: _____, cause?_____)<br>Mother's CANCER history or major medical problems: | FATHER<br>❑ living ❑ deceased (at age: _____, cause?_____)<br>Father's CANCER history or major medical problems: |

OTHER FAMILY MEMBERS WITH HISTORY OF CANCER: list relationship and type of cancer

## Smoking History

Do you currently smoke? ❑ Y ❑ N
How many years: _____ About how many packs/day: _____

Have you ever smoked? ❑ Y ❑ N
When did you quit, if you used to smoke? _____
How many years did you smoke: _____ About how many packs/day: _____

## Alcohol, Caffeine or Drug Use History

Do you currently drink alcoholic beverages? ❑ No ❑ Yes
What kind, how often, and how much:

Have your current habits of alcohol use changed? ❑ No ❑ Yes, Explain:

Caffeine? (coffee, soft drinks, etc.) ❑ No ❑ Yes how much:

Other drug use, at present or in past? ❑ No ❑ Yes, Describe:

## Social History

Are you married? ❑ No ❑ Yes, how long: _____
Do you have any children?: ❑ No ❑ Yes, ages: _____

Are you currently working? ❑ No ❑ Yes
What is your occupation (or what was it before you retired, were disabled, etc.)?: _____
How long have you/did you work at your job(s)?: _____ years
Any chemical or other hazardous material exposure at work? ❑ No ❑ Yes, Explain:
Are you currently on disability at your job? ❑ Y ❑ N

# SYSTEM-SPECIFIC QUESTIONS

## *(Circle 'Yes' or 'No'. If 'Yes', please explain)*

| GENERAL | | |
|---|---|---|
| Weight loss | No | Yes:_____ |
| Weight gain | No | Yes:_____ |
| Fever | No | Yes:_____ |
| Chills | No | Yes:_____ |
| Night sweats | No | Yes:_____ |
| Fatigue | No | Yes:_____ |

| EYES | | |
|---|---|---|
| Use glasses or contacts? | No | Yes:_____ |
| Painful, itchy, or red eyes | No | Yes:_____ |
| Blurry vision | No | Yes:_____ |
| Double vision | No | Yes:_____ |
| Spots, specks, flashing lights | No | Yes:_____ |
| Excess tearing | No | Yes:_____ |
| Very dry eyes | No | Yes:_____ |

| EARS, NOSE, MOUTH, THROAT | | |
|---|---|---|
| Use hearing aids | No | Yes:_____ |
| Changes in hearing | No | Yes:_____ |
| Pain in ears | No | Yes:_____ |
| Ringing in ears | No | Yes:_____ |
| Discharge from ears | No | Yes:_____ |
| Nasal bleeding/discharge | No | Yes:_____ |
| Stuffy nose | No | Yes:_____ |
| Changes in smell | No | Yes:_____ |
| Changes in taste | No | Yes:_____ |
| Use dentures? | No | Yes:_____ |
| Hoarseness | No | Yes:_____ |
| Spitting up blood | No | Yes:_____ |
| Pain in mouth or throat | No | Yes:_____ |
| Difficulty moving tongue | No | Yes:_____ |
| Difficulty swallowing | No | Yes:_____ |

| SKIN | | |
|---|---|---|
| Rashes | No | Yes:_____ |
| Swelling | No | Yes:_____ |
| Sores | No | Yes:_____ |
| Itching | No | Yes:_____ |
| Dryness | No | Yes:_____ |
| Color changes/yellowing | No | Yes:_____ |
| Changes in hair or nails | No | Yes:_____ |

| FEMALES: BREAST | | |
|---|---|---|
| Lumps | No | Yes:_____ |
| Soreness | No | Yes:_____ |
| Clear nipple discharge | No | Yes:_____ |
| Bloody nipple discharge | No | Yes:_____ |
| Perform regular self-exams | No | Yes:_____ |

| RESPIRATORY | | |
|---|---|---|
| Cough | No | Yes:_____ |
| Excess sputum production | No | Yes:_____ |
| Coughing up blood | No | Yes:_____ |
| Shortness of breath | No | Yes:_____ |
| History of pneumonia | No | Yes:_____ |
| History of tuberculosis | No | Yes:_____ |

| CARDIAC | | |
|---|---|---|
| Heart palpitations | No | Yes:_____ |
| Heart murmurs | No | Yes:_____ |
| Heart attacks | No | Yes:_____ |
| Chest pain | No | Yes:_____ |
| Pacemaker | No | Yes:_____ |

| GASTROINTESTINAL | | |
|---|---|---|
| Heartburn | No | Yes:_____ |
| Nausea | No | Yes:_____ |
| Vomiting | No | Yes:_____ |
| Indigestion | No | Yes:_____ |
| Changes in stool color | No | Yes:_____ |
| Changes in stool size | No | Yes:_____ |
| Blood in stool | No | Yes:_____ |
| Constipation | No | Yes:_____ |
| Diverticulosis/Diverticulitis | No | Yes:_____ |
| Diarrhea | No | Yes:_____ |

# SYSTEM-SPECIFIC QUESTIONS (cont.)

## *(Circle 'Yes' or 'No'. If 'Yes', please explain)*

| FEMALES: GENITAL | | |
|---|---|---|
| How old at first period? | Age:_____ | |
| Regular periods | No | Yes:_____ |
| Pain with intercourse | No | Yes:_____ |
| Very painful periods | No | Yes:_____ |
| Birth control pill use | No | Yes:_____ |
| How old at menopause? | Age:_____ | |
| Decreased libido | No | Yes:_____ |
| Vaginal discharge | No | Yes:_____ |
| Hormone replacement use | No | Yes:_____ |
| Complications w/ pregnancies | No | Yes:_____ |

| MALES: GENITAL | | |
|---|---|---|
| Hernias | No | Yes:_____ |
| Discharge from penis | No | Yes:_____ |
| Testicular pains | No | Yes:_____ |
| Testicular masses | No | Yes:_____ |
| Decreased libido | No | Yes:_____ |

| ENDOCRINE | | |
|---|---|---|
| Thyroid dysfunction | No | Yes:_____ |
| Hot/cold intolerance | No | Yes:_____ |
| Excessive sweating | No | Yes:_____ |
| Excessive thirst | No | Yes:_____ |
| Excessive hunger | No | Yes:_____ |

| PSYCHIATRIC | | |
|---|---|---|
| Nervousness | No | Yes:_____ |
| Depression | No | Yes:_____ |
| Mood swings | No | Yes:_____ |
| Feelings of hopelessness | No | Yes:_____ |

| VASCULAR | | |
|---|---|---|
| Poor circulation | No | Yes:_____ |
| Leg cramps | No | Yes:_____ |
| Varicose veins | No | Yes:_____ |
| Clots in veins | No | Yes:_____ |

| MUSCULOSKELETAL | | |
|---|---|---|
| Muscle or joint pains | No | Yes:_____ |
| Stiffness | No | Yes:_____ |
| Arthritis | No | Yes:_____ |
| Gout | No | Yes:_____ |
| Backache | No | Yes:_____ |
| Swollen extremities | No | Yes:_____ |
| Decreased motion arms/legs | No | Yes:_____ |

| NEUROLOGIC | | |
|---|---|---|
| Fainting spells | No | Yes:_____ |
| Blackouts | No | Yes:_____ |
| Numbness | No | Yes:_____ |
| Weakness | No | Yes:_____ |
| Paralysis | No | Yes:_____ |
| Coordination problems | No | Yes:_____ |
| Migraines | No | Yes:_____ |
| Tremors | No | Yes:_____ |
| Involuntary movements | No | Yes:_____ |

| URINARY | | |
|---|---|---|
| Pain or burning with urination | No | Yes:_____ |
| Blood in urine | No | Yes:_____ |
| Incontinence | No | Yes:_____ |
| Kidney Stones | No | Yes:_____ |
| Other: | | |

**CERTIFICATION**

I attest that all of the information in this document is true and correct to the best of my knowledge and understand my physician will base his opinions and judgments on the same.

_____

_____

Patient signature Date

# THIS PAGE FOR MALES ONLY WITH PROSTATE CANCER

## Urinary Function Scoring

| ***URINARY SYMPTOM SCORING*** *Circle the number that appears BELOW the COLUMN HEADING DESCRIPTION* | **Not at all** | **Less than 1 time in 5** | **Less than half the time** | **About half the time** | **More than half the time** | **Almost always** |
|---|---|---|---|---|---|---|
| **Incomplete Emptying:** In the past month on average, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Frequency of Urination:** In the past month on average, how often have you had to urinate again less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Intermittency:** In the past month on average, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Urgency:** In past month on average, how often was it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Weak Stream**: In the past month on average, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Straining:** In the past month on average, how often did you push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Urination at Nightime:** In the past month on average, how many times each night did you get up to urinate from when you went to bed until you woke in the morning? | None 0 | 1 time 1 | 2 times 2 | 3 times 3 | 4 times 4 | 5+ times 5 |

TOTAL IPPS SCORE: _____ ❑ 0-7: Mild Symptoms ❑ 8-19: Moderate Symptoms ❑ 20-35: Severe Symptoms

CURRENTLY, are you taking any medications to help with urination?:
❑ No ❑ Yes: (circle or write in) Flomax Uroxatral Hytrin Cardura Detrol Other:_____

Do you have PAIN when you urinate?
❑ NONE ❑ Mild ❑ Moderate Pain or I Need Medications for pain ❑ Severe Pain ❑ Disabling Pain

Do you have any URINARY LEAKAGE OR INCONTINENCE?:
❑No ❑ Yes: (select one) ❑ minor post-stream dribbling, no pads required ❑ I use #____ per day for leakage
❑ leakage interferes w/ my daily activities

Do you have any URINARY BLEEDING? ❑No ❑ Yes: ❑ daily ❑ weekly

**HORMONE THERAPY USAGE:**
Have you received "Hormone Therapy" from your Urologist (typically an injection)?
❑ No ❑ Yes:
If YES, answer the following:
What was the date of your FIRST ever hormone injection?:_____
How long many months was this injection supposed to last?(circle one): 1 mo. 3 mos. 6 mos.
Are you scheduled to have another hormone injection? ❑ No ❑ Yes

# THIS PAGE FOR MALES ONLY WITH PROSTATE CANCER

## Rectal Symptoms

Do you have any RECTAL BLEEDING?:
❑ No ❑ Occasional, but no doctor intervention needed ❑ Yes, it required intervention or cauterization

Do you have any RECTAL PAIN?
❑ No ❑ Yes, mild ❑ Yes, interferes with my daily activities ❑ Yes, Loss of stool control

How would you describe your Bowel Movements on average?
❑ Normal ❑ Occasional Diarrhea ❑ Constant Diarrhea ❑ Occasional Constipation ❑ Constant Constipation
❑ Alternating Diarrhea and Constipation

Are you taking any medication for Stool or Rectal Pain?
❑ No ❑ Yes: (circle or write in): Immodium Lomotil Suppository Proctofoam Other:_____

## Erectile Function Scoring

Are you sexually active now? ❑ Yes ❑ No ❑ No, because of the hormones I'm still taking

Are you taking any medication or aids for Erectile Dysfunction?
❑ No ❑ Yes: (circle or write in): Viagra Levitra Cialis Penile Implant Other:_____

| ***Erectile Function Scoring*** | ***Circle one answer per row following each question*** | | | | |
|---|---|---|---|---|---|
| **Over the past 6 months (or if you just finished radiation, based on the time since completing RT):** | 1 | 2 | 3 | 4 | 5 |
| How do you rate your confidence that you could get and keep an erection? | Very low | Low | Moderate | High | Very high |
| When you have erections with sexual stimulation, how often were your erections hard enough for penetration? | Almost never or never | Much less than half the time | About half the time | Much more than half the time | Almost always or always |
| During sexual intercourse, how often were are able to maintain your erection after you had penetrated (entered) your partner? | Almost never or never | Much less than half the time | About half the time | Much more than half the time | Almost always or always |
| During sexual intercourse how difficult is it to maintain an erection to the completion of intercourse? | Extremely difficult | Very difficult | Difficult | Slightly difficult | Not difficult |
| When you attempt sexual intercourse, how often was it satisfactory for you? | Almost never or never | Much less than half the time | About half the time | Much more than half the time | Almost always or always |

TOTAL IIEF Score:_____