NexGen Oncology Health Questionnaire

Date completed: _____

Patient Name: _____ Date of Birth: _____ Age: ____
Gender: ☐ Male ☐ Female Race/Ethnicity: _____
Referring Physician: _____ Family Physician: _____
Other Physicians: _____ (if different from Referring Physician)

Primary reason for your visit: _____

CONDITION / SYMPTOMS

Are you currently experiencing any of the conditions or symptoms below?

Condition / Symptom	Yes	No		Condition / Symptom	Yes	No
Headache	☐	☐		Swollen feet or legs	☐	☐
Dizziness	☐	☐		Palpitations	☐	☐
Fainting	☐	☐		Nausea/Vomiting	☐	☐
Double vision	☐	☐		Appetite changes (describe)	☐	☐
Blurry vision	☐	☐		Vomiting blood	☐	☐
Blind spots	☐	☐		Yellow eyes or skin (jaundice)	☐	☐
Eye pain, swelling or discharge	☐	☐		Pain (specify location)	☐	☐
Change in hearing	☐	☐		Diarrhea/constipation	☐	☐
Change in nose breathing of stuffiness	☐	☐		Red blood in stool	☐	☐
Nose bleeds	☐	☐		Black tarry stools	☐	☐
Mouth sores, pain or bleeding	☐	☐		White chalky stools	☐	☐
Swollen lymph nodes	☐	☐		Green or yellow stools	☐	☐
Stiff neck	☐	☐		Weight loss	☐	☐
Skin rash, tumors, other changes	☐	☐		Difficulty or pain with urination	☐	☐
Cough	☐	☐		Frequent urination (# times/night)	☐	☐
Cough with blood	☐	☐		Pus or blood in urine	☐	☐
Shortness of breath at rest	☐	☐		Problems with bladder or bowel control	☐	☐
Shortness of breath with exercise	☐	☐		Feeling cold/hot	☐	☐
Shortness of breath at night	☐	☐		Easy bruising/bleeding	☐	☐
Shortness of breath lying flat	☐	☐		Seizures or fits	☐	☐
Pain on deep breathing	☐	☐		Personality change	☐	☐
Fever	☐	☐		Memory loss	☐	☐
Chills	☐	☐		Numbness or tingling	☐	☐
Sweats	☐	☐		Loss of strength in specific areas of the body	☐	☐
Chest pain	☐	☐		Decreased coordination	☐	☐
Palpitations	☐	☐		Speech problems	☐	☐
Swollen veins	☐	☐		Other problems (specify)	☐	☐

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MEDICAL HISTORY

Have YOU had any of the following health problems? Please specify age/year and treatment

Health problem	Yes	No		Age/Year/ Treatment	Health problem	Yes	No	Age/Year/ Treatment
Asthma	☐	☐			Pneumonia	☐	☐	
Bleeding problems/disorder	☐	☐			Pleurisy	☐	☐	
Clotting disorder / DVT	☐	☐			Pulmonary emboli (blood clots in lungs)	☐	☐	
Diabetes	☐	☐			Rheumatic fever	☐	☐	
Emphysema	☐	☐			Chronic bronchitis	☐	☐	
Hypertension/High blood pressure	☐	☐			Rheumatoid arthritis	☐	☐	
Fluid around the heart	☐	☐			Thyroid disease	☐	☐	
Heart attack or heart problems (specify) Angina/chest pains	☐	☐			Lung disease (specify)	☐	☐	
Glaucoma / cataracts	☐	☐			Cancer (specify)	☐	☐	
Other eye problems (specify)	☐	☐			Anemia	☐	☐	
Kidney problems (specify)	☐	☐			Stokes / TIAs	☐	☐	
Recurrent sinusitis	☐	☐			Thyroid problems	☐	☐	
Nose disease	☐	☐			Liver problems (specify)	☐	☐	
Mouth disease	☐	☐			Tuberculosis	☐	☐	
Dental problems	☐	☐			Seizure disorder	☐	☐	
Throat disease	☐	☐			Physiological problems/Depression	☐	☐	
Hearing loss	☐	☐			Sexual problems	☐	☐	
Heartburn/Reflux	☐	☐			Other (specify)			

HOSPITALIZATIONS, PRIOR LAB RESULTS, BIOPSIES, OR SURGERIES:

Recent Hospitalization? ☐ Yes ☐No (*Continued on back page if needed)

Surgery / Hospitalization	Year (Date)/Age	Physician / Hospital
*		

Recent labs tests performed: ☐ Yes ☐ No Where performed? _____

Blood _____

Urine _____

Recent Biopsy? ☐ Yes ☐ No (specify) _____

Date of last Chest X-ray or other x-rays: _____ Where Performed? _____

BLOOD TRANSFUSIONS

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, most recent transfusion? _____
If yes, did you have a reaction? ☐ Yes ☐ No

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REPRODUCTIVE HISTORY (For Women Only)

Number of pregnancies ____ Miscarriages ____ Age at first delivery _____ Number of children _____
Did you breast feed? ☐ Yes ☐ No If yes, for how many months? _____

Age at first period _____ Are you still having periods? ☐ Yes ☐ No Date of last Menstrual Period? _____
How long is your menstrual period ____days? How often? _____
Age at menopause _____

Have you had a hysterectomy? (uterus removed)	☐Yes	☐ No	When? _____
Have your ovaries been removed?	☐ Yes	☐ No	When? _____
Are you currently taking birth control pills?	☐ Yes	☐ No	Started _____
Have you every taken birth control pills?	☐ Yes	☐ No	How long? _____
Are you currently taking Hormones?	☐ Yes	☐ No	
Have you taken Hormones in the past?	☐ Yes	☐ No	How long? _____
Do you practice self breast exam monthly?	☐ Yes	☐ No	

Date of last pap smear/pelvic exam? _____ Results? ☐ normal ☐ abnormal (specify)_____
Date of Last Mammogram? _____ Results? ☐ normal ☐ abnormal (specify)_____

FAMILY HISTORY

Is your Mother alive? ☐ Yes ☐ No
If not, what age was she when she died? ____
What did she die of? _____

Is your Father alive? ☐ Yes ☐ No
If not, what age was he when he died? _____
What did he die of? _____

How many siblings do you have? Brothers _____ Sisters _____
Significant Medical Problems for any of them? (Please list)_____

Is your maternal grandmother alive ☐ Yes ☐ No maternal grandfather alive? ☐ Yes ☐ No

Is your paternal grandmother alive ☐ Yes ☐ No paternal grandfather alive? ☐ Yes ☐ No
If not, what age was she/he when they died? ____
What cause of death? _____

If not, what age was she/he when died? _____
What cause of death? _____

Significant medical problems for any family members? (diabetes, cancer, heart problems) _____

SOCIAL HISTORY

Marital Status: (please check one) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Number of Children: _____
Who lives with you? _____ ☐ Live alone ☐ Spouse ☐ Children ☐ Parents ☐ Friend

I currently ☐ do not work ☐ work as _____

Have you worked with or been exposed to hazardous chemicals? ☐ Yes ☐ No Specify: _____
(Circle all that apply – asbestos, benzene, lead, mercury, other specify _____)

Have you ever smoked? ☐ Yes ☐ No
What type? _____ # packs per day? _____ Since YEAR: _____ If quit, when? _____

Do you drink alcohol? ☐ Yes ☐ No
What type? _____ How much? _____ How often/# days/week? _____ If quit, when? _____

Do you drink beverages with caffeine? How much? _____ How often? _____

Other products (circle all that apply)? Pipe, chewing tobacco, snuff
How much? _____ How often? _____

ALLERGIES

Do you have any Allergies to medications? (Circle) ☐ **No** (skip to next section) ☐ **Yes** (please list)

Medication	Type of Reaction/Severity	Approximate Date of Reaction

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MEDICATIONS:

Are you currently taking medications ☐ Yes ☐ No
(if yes, please list all prescription and over the counter medications including, vitamins, supplements, herbs, and aspirin)

Name	Dose / Strength	Frequency	Start date	Reason for taking

PREVENTIVE HEALTH MAINTENANCE

Do you use sunscreen regularly? ☐ Yes ☐ No

Female:

Date of last bone density _____ Results? ☐ normal ☐ abnormal (specify)_____
Date of last colonoscopy _____ Results? ☐ normal ☐ abnormal (specify)_____
Date of last complete physical _____ Last pneumonia vaccine or other vaccination _____

Male:

Date of last prostate exam/PSA_____ Results? ☐ normal ☐ abnormal (specify)_____
Date of last colonoscopy _____ Results? ☐ normal ☐ abnormal (specify)_____
Date of last complete physical _____ Last pneumonia vaccine or other vaccination _____

RESOURSE NEEDS

Do you have concerns that you would like to discuss? ☐ Yes ☐ No Specify _____

Transportation, home care assistance, health care expenses? ☐ Yes ☐ No
Are you interested in joining a support group? ☐ Yes ☐ No

Do you have daily transportation available? ☐ Yes ☐ No

Do you have a signed Durable Power of Attorney, Directive to Physician and / or Living Will?
☐ Yes ☐ No Where is it kept? _____

GENERAL CONDITION:

How would you describe your current activity level?

- ☐ Fully active and able to carry on all normal activity without restriction
- ☐ Able to perform activities such as light house work, office work, shopping, etc, but not able to perform strenuous activities.
- ☐ Able to take care of yourself, but not able to perform light work. Out of the bed more than half of the day and able to leave home
- ☐ Only able to stay at home, in a bed or a chair more than half of the day, but able to take care of yourself to some degree
- ☐ Completely disabled and cannot carry on any self-care. Totally confined to bed or chair.