Medical questionnaire

Personal Information			
Name:		Occupation:	
Address:			
City:		State:	Zip:
Home Phone:	Business Phone:	Cell Phone:	
E-mail Address:			
Sex: ☐ Male ☐ Female	Date of Birth:	Age:	
Person to Notify in Emergency:			
Relationship:		Phone:	
Physician Name:		Phone:	

Medical History

Check all below that apply to you.
For each checked item, include a brief explanation and date of occurrence.

☐	Rheumatic fever / heart murmur	
☐	High blood pressure	
☐	Chest discomfort	
☐	Heart abnormalities (racing, skipping)	
☐	Abnormal ECG	
☐	Heart problems	
☐	Coughing up blood	
☐	Stomach or intestinal problems	
☐	Anemia	
☐	Stroke	
☐	Sleeping problems	
☐	Migraine or recurrent headaches	
☐	Dizziness or fainting spells	

	Leg pain after walking short distances	
	Back/neck pain/injuries	
	Foot/ankle problems	
	Knee/hip problems	
	Lymphedema	
	High cholesterol	
	Diabetes	
	Thyroid problems	
	Lung disease	
	Respiratory problems/asthma	
	Chronic or recurrent cough	
	Disease of arteries	
	Varicose veins	
	Increased anxiety/depression	
	Recurrent fatigue	
	Arthritis	
	Swollen/stiff/painful joints	
	Epilepsy	
	Vision/hearing problems	

Women Only

	Currently Pregnant	
	Menstrual irregularities	

Operations
Starting With Most Recent

1		Date:
2		Date:

3		Date:	
Hospitalizations Starting With Most Recent			
1		Date:	Length:
2		Date:	Length:
3		Date:	Length:

Family Medical History

	Condition	Family Member(s)
	High blood pressure	
	Heart attack	
	Heart surgery	
	High cholesterol	
	Stroke	
	Diabetes	
	Obesity	
	Early death	
	Cancer	
	Other family illnesses	

Medication Information

Current Medication		Dosage
1		
2		
3		
4		

Drug Allergies:

Cancer Specific History	
Type of Cancer:	Date of Diagnosis:
Specific Location: (left/right breast, area of brain, etc.)	
Presenting Symptoms: (symptoms that led to cancer diagnosis)	
Cancer Surgery:	☐ Yes ☐ No
Type of Surgery:	Date(s) of Surgery:
Currently Undergoing Chemotherapy:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Currently Undergoing Radiation:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Currently Undergoing Nuclear:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Complications: (infection, recurrence, etc.)	
Current Medical Concerns Due to Cancer:	
Medications for Cancer / Cancer Complications:	
Other Medications: (prescribed, OTC, vitamins, herbs, etc.)	
Primary Care Physician at Time of Diagnosis:	
Surgeon:	
Oncologist:	
Radiation Oncologist:	

Lifestyle / Activity Evaluation				
Smoking				
1	Have you ever smoked cigarettes, cigars, pipe?	Yes ☐	No ☐	Type:
2	Do you currently smoke?	Yes ☐	No ☐	Amount:
3	If you smoke, at what age did you start?			
4	If you quit, at what age did you quit?			
Diet				
1	Do you consider yourself overweight?	Yes ☐	No ☐	
	If yes, how long have you been overweight?			
2	How many meals do you typically eat per day?			
Alcohol & Caffeine Use				
1	How many cups of caffeinated beverages do you consume per day?			
2	How many units of alcohol do you consume per week?			
Stress				
1	Do you consider your days stressful?	Yes ☐	No ☐	
	If yes, what is the nature of your stress?			
2	How many hours do you sleep per night?			
3	Is your sleep sound?	Yes ☐	No ☐	
4	Do you practice any form of meditation?	Yes ☐	No ☐	
Exercise				
1	Do you exercise on a regular basis?	Yes ☐	No ☐	
2	What exercises do you participate in regularly?			
3	How many days per week do you exercise regularly?			
4	What Orthopedic problems do you have or have you had in the past?			
5	Are there any activities or exercises your physician has advised you to AVOID?			