Inland Hematology Oncology Medical Group Inc.
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"PATIENT HISTORY QUESTIONNAIRE"

DATE:______________

NAME:____

AGE:______________ **SEX: F**________ **M**________

OCCUPATIONS:__________________________________

MEDICINES TAKEN REGULARLY:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

DRUG ALLERGIES (WHAT HAPPENS?):

______________________ ______________________

MEDICAL HISTORY:

HAVE YOU EVER HAD? YES=Y; NO=N:

DIABETES:	Y_______	N_______
CANCER:	Y_______	N_______
ASTHMA:	Y_______	N_______
ANEMIA:	Y_______	N_______
EMPHYSEMA:	Y_______	N_______
HIGH BLOOD PRESSURE:	Y_______	N_______
HEART DISEASE:	Y_______	N_______
BLEEDING TENDENCY:	Y_______	N_______
BLOOD TRANSFUSIONS:	Y_______	N_______
HEPATITIS:	Y_______	N_______
ULCERS:	Y_______	N_______
KIDNEY DISEASE:	Y_______	N_______

SURGICAL HISTORY: (OPERATIONS ON):

APPENDIX:	Y_______	N_______
GALL BLADDER:	Y_______	N_______
STOMACH:	Y_______	N_______
BREAST:	Y_______	N_______
UTERUS:	Y_______	N_______
OVARIES:	Y_______	N_______
PROSTATE:	Y_______	N_______
THYROID:	Y_______	N_______
HEART:	Y_______	N_______
LUNG:	Y_______	N_______
INJURIES:	Y_______	N_______

PRESENT AND PAST TOBACCO USE:

____

PRESENT AND PAST ALCOHOL USE:

____

FAMILY HISTORY

ANEMIA:	____________________
BLEEDING TENDENCY:	____________________
LEUKEMIA:	____________________
CANCER:	____________________
HEART DISEASE:	____________________
DIABETES:	____________________

RELATIVES: (AGES AND THEIR HEALTHS)

FATHER:	________________________
MOTHER:	________________________
SIBLINGS:	________________________
	________________________
	________________________
CHILDREN:	________________________
	________________________
	________________________

DO YOU HAVE? (YES=Y; NO=N)

FEVERS EVERY DAY:	________
DRENCHING NIGHT SWEATS:	________
WEIGHT LOSS (HOW MUCH):	________
POOR APPETITE:	________
SWALLOWING DIFFICULTY:	________
NAUSEA/ VOMITING:	________
CONSTIPATION/ DIARRHEA:	________
BLOODY OR BLACK STOOLS:	________
RASHES:	________
BLEEDING (FROM WHERE):	________
LOSS OF HEARING:	________
CHRONIC COUGH:	________
FREQUENT CHEST PAINS:	________
COLORED SPUTUM:	________
DIZZINESS/ PASSING OUT:	________
WEAKNESS/ PARALYSIS:	________
CHANGE IN URINE COLOR:	________
PAIN:	________
OTHER:	________

REFERRING MD:____________________________

PRIMARY CARE MD:_________________________

SURGEON:________________________________

THANK YOU