Inland Hematology Oncology Medical Group, Inc.
401- C. East Highland Ave., San Bernardino, CA 92404

"PATIENT HISTORY QUESTIONNAIRE"

DATE: _____

NAME: _____

AGE: _____ SEX: F_____ M_____

OCCUPATION(S): _____

MEDICINES TAKEN REGULARLY:

_____ _____

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES (WHAT HAPPENS?):

_____

_____

MEDICAL HISTORY:

HAVE YOU EVERY 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_____

FAMILY HISTORY:

_____

_____

_____

_____

_____

_____

PAST AND PRESENT TOBACCO USE:

_____

CURRENT SMOKER: Y_____ N_____

START DATE OF SMOKING: _____

FORMER SMOKER: Y_____ N_____

PAST AND PRESENT ALCOHOL USE:

_____

DO YOU HAVE: YES = Y NO = N

DRENCHING NIGHT SWEATS:	Y_____	N_____
BLOODY OR BLACK STOOLS:	Y_____	N_____
DIFFICULTY SWALLOWING:	Y_____	N_____
CONSTIPATION/ DIARRHEA:	Y_____	N_____
CHANGE IN URINE COLOR:	Y_____	N_____
FREQUESNT CHEST PAINS:	Y_____	N_____
DIZZINESS/ PASSING OUT:	Y_____	N_____
WEAKNESS/ PARALYSIS:	Y_____	N_____
FEVERS EVERY DAY:	Y_____	N_____
NAUSEA/ VOMITING:	Y_____	N_____
COLORED SPUTUM:	Y_____	N_____
LOSS OF HEARING:	Y_____	N_____
CHRONIC COUGH:	Y_____	N_____
POOR APPETITE:	Y_____	N_____
PAIN:	Y_____	N_____
RASHES:	Y_____	N_____
WEIGHT LOSS:	Y_____	N_____

IF SO, HOW MUCH: _____

BLEEDING: Y_____ N_____

IF SO, FROM WHERE: _____

OTHER: _____

_____

_____

REFERRING MD: _____

PRIMARY CARE MD: _____

SURGEON: _____

Thank you for your cooperation

revised 8/11/2011