Name _____ Date: _____

Northwest Oncology, P. C.

Patient Health Survey

HISTORY OF PAST ILLINESS: Have you had

Childhood:

❑ Congenital Abnormalities ❑ Rheumatic Fever or Heart Disease

Adult:

❑ Asthma ❑ High Blood Pressure ❑ Cancer - Site_____

❑ Diabetes ❑ Ulcer or Gastritis ❑ Thyroid Problems

❑ Tuberculosis ❑ Kidney problem ❑ Liver Problems

❑ Blood Problem ❑ Venereal Disease ❑ Heart Failure

❑ Heart Attack ❑ Abnormal Heart Rhythm

Have you ever had a transfusion No Yes

Have You ever been hospitalized? No Yes

If Yes, For What reason? _____

_____

Most Recent Immunizations:

Hepatitis B _____ (date)

Flu Vaccine _____ (date)

Pneumovax _____ (date)

OPERATIONS:

Have you ever had any surgery? No Yes

List: ❑ Appendectomy ❑ Hysterectomy (if so reason _____)

❑ Ovaries Removed ❑ Joint Replacement

❑ Gallbladder ❑ Bypass (if so, what _____)

❑ Other _____

_____

_____

ALLERGIES:

_____

MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Circle One: Single Married Separated

Divorced Widowed Significant Other

With whom do you live?

_____

Recreational Drug Usage? No Yes

Do you have any problems with sexual functions? No Yes

Alcoholic Beverages Never _____ < 1 per Week _____

1 – 5 Per Week _____ Other _____

Tobacco: ❑ Never Smoked ❑ Quit _____ years ago

❑ Years Smoked _____ ❑ Pack per day _____

Are you employed? No ____ Full time _____ Part Time _____

What is your Job? _____

_____

_____

Have you been exposed to fumes, dusts or solvents? _____

Family History	Age	Health	If Deceased Age of Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or Grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendency	No	Yes
Type					

SYSTEMIC REVIEW:

General: Maximum weight _____ Minimum weight _____

Recent weight change? No Yes

Have you been in good health most of your life? No Yes

Have you recently had?

❑ Weakness ❑ Fever ❑ Chills ❑ Night Sweats

❑ Fainting ❑ Problems Sleeping

Skin:

Name _____ Date: _____

Northwest Oncology, P. C.

Patient Health Survey

Skin Disease . . . . . No Yes
Jaundice . . . . . No Yes
Hives, eczema or rash . . . . . No Yes
No Yes

Head-Eyes-Ears-Nose-Throat No Yes
Dry eyes or mouth . . . . . No Yes
Bleeding Gums – Frequent or Constant. . . . . No Yes
Blurred Vision . . . . . No Yes
Date of last Eye Exam _____
Sneezing or runny nose . . . . . No Yes
Nosebleeds – Frequent . . . . . No Yes
Chronic sinus trouble . . . . . No Yes
Ear disease . . . . . No Yes
Impaired hearing . . . . . No Yes
Dizziness or sensation of room spinning . . . . . No Yes
Frequent or severe headaches . . . . . No Yes

Respiratory:
Asthma or Wheezing . . . . . No Yes
Difficulty breathing . . . . . No Yes
Any trouble with lungs . . . . . No Yes
Pleurisy or Pneumonia . . . . . No Yes
Cough up Blood (ever) . . . . . No Yes

Cardiovascular:
Chest pain, pressure, or tightness . . . . . No Yes
Shortness of breath with walking or lying down . . . . . No Yes
Difficulty walking two blocks . . . . . No Yes
Palpitations . . . . . No Yes
Swelling of hands, feet or ankles . . . . . No Yes
Awakening in the nights smothering . . . . . No Yes
Heart murmur . . . . . No Yes

Gastrointestinal:
Vomiting blood or flood . . . . . No Yes
Gallbladder disease . . . . . No Yes
Change in appetite . . . . . No Yes
Hepatitis/Jaundice . . . . . No Yes
Painful bowel movements. . . . . No Yes
Bleeding with bowel movements . . . . . No Yes
Black stools . . . . . No Yes
Hemorrhoids or piles . . . . . No Yes
Recent change in bowel habits . . . . . No Yes
Frequent diarrhea . . . . . No Yes
Heartburn or indigestion . . . . . No Yes
Cramping or pain in the abdomen . . . . . No Yes
Does food stick in throat . . . . . No Yes

Endocrine:
Hormone therapy . . . . . No Yes
Any change in hat or glove size . . . . . No Yes
Any change in hair growth . . . . . No Yes
Have you become colder than before or skin dryer . . . . . No Yes

Neck:
Stiffness . . . . . No Yes
Enlarged glands . . . . . No Yes

Genitourinary:
Loss of urine . . . . . No Yes
Blood in urine . . . . . No Yes
Frequent urination . . . . . No Yes
Burning or painful .. . . . . No Yes
Nighttime urinating . . . . . No Yes
Kidney trouble . . . . . No Yes
Problem stopping/starting flow of urine . . . . . No Yes
Testicular mass . . . . . No Yes
Testicular pain . . . . . No Yes
Prostate problem . . . . . No Yes
Sexual dysfunction . . . . . No Yes
STD/ AIDS risk . . . . . No Yes

Gynecological:
First day of last period _____
Age periods started _____
How long do periods last? _____ Days
Frequency of periods every _____Days
Pain with periods . . . . . No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast lump . . . . . No Yes
Abnormal vaginal discharge . . . . . No Yes
Breast discharge . . . . . No Yes
Pain with intercourse . . . . . No Yes
Skin change of breast . . . . . No Yes
Nipple retraction . . . . . No Yes

Locomotor-Musculoskeletal:
Stiffness or pain in joints (check all the apply)
❑ Finger ❑ Hands ❑ Elbows ❑ Shoulders ❑ Neck
❑ Toes ❑ Back ❑ Hip ❑ Knee ❑ Foot
❑ Wrist ❑ hip ❑ Temporomandibular Joint
Weakness of muscles or joints . . . . . No Yes
Any difficulty in walking . . . . . No Yes
Pain in calves or buttocks on walking relieved by rest . . . . . No Yes

Neuro-Psychiatric:
❑ Transient blindness ❑ Tremor ❑ Numbness in finger ❑ Weakness
Have you ever had counseling for your mental health? . . . . . No Yes
Have you ever been advised to see a psychiatrist? . . . . . No Yes
Do you ever have, or have had, fainting spells? . . . . . No Yes
Convulsions . . . . . No Yes
Paralysis . . . . . No Yes
Problem with coordination . . . . . No Yes
Domestic violence . . . . . No Yes
Depression symptoms (difficulty sleeping, loss of appetite,
Loss of interest in activities, feelings of hopelessness) . . . . . No Yes

Hematologic:
Are you slow to heal after cuts? . . . . . No Yes
Phlebitis of blood clots in veins . . . . . No Yes
Have you had difficulty with bleeding excessively after No Yes
tooth extraction or surgery? . . . . . No Yes
Have you had abnormal bruising or bleeding? . . . . . No Yes