

Lifespring Cancer Treatment Center

Health Questionnaire

Today's Date _____

Name _____ Date of Birth _____
(last) (first) (middle)

Reason for this visit (chief complaint) : _____

Medical History

Illness, injuries: Date

Surgeries/hospitalizations: Date/Reason

_____	_____
_____	_____
_____	_____
_____	_____

Current Medications (include non-prescription)

Name of medicine	Strength of Dose (mg)	How often taken	Reason taken

Habits:

Smoking? Yes / No How many packs each day? _____ For how many years? _____

Alcohol? Yes / No What type? _____ How many drinks per day? _____

Have you ever used 'street' (illegal) intravenous drugs? Yes / No

Have you ever been tested, or do you want to be tested for the HIV/AIDS virus? Yes / No

Allergies _____

Family History

	Current age or	Age at death	Cancer? Illness? Cause of death		Current age or	Age at death	Cancer? Illness? Cause of death
Father				Mother			
Brothers				Sisters			
Children				Other relatives			

Social History

() Married () Single () Divorced (Year _____) () Widowed (Year _____)

Present marriage/number of years _____ Previous marriage/number of years _____

Present occupation _____ Previous Occupations _____

Education _____ Spouse's Occupation _____

Persons currently living in your home _____

Do you have a living will? () No () Yes (please provide a copy)

Review of Systems

General Weight loss _____ Loss of appetite _____ Fever _____ Chills _____ Others _____

Skin: Redness _____ Swelling _____ Moles _____ Ulcerations _____ Others _____

Eyes Vision changes _____ Cataracts _____ Redness _____ Swelling _____ Pain _____ Others _____

Ears Discharge _____ Hearing Loss _____ Others _____

Nose Discharge _____ Bleeding _____ Others _____

Throat Swelling _____ Pain _____ Discharge _____ Others _____

Breast Lumps _____ Discharge _____ Bleeding _____ Pain _____ Others _____

Lungs Cough _____ Blood in sputum _____ Shortness of breath _____ Asthma _____

Tuberculosis _____ Others _____

Heart Chest pain _____ Heart palpitation _____ High blood pressure _____ Others _____

Gastrointestinal Nausea _____ Vomiting _____ Diarrhea _____ Constipation _____

Abdominal/stomach pain _____ Others _____

Urinary Kidney problems _____ Bladder problems _____ Blood in urine _____

Frequent urination _____ Prostate problems _____ Others _____

Hormonal Diabetes _____ Thyroid problem _____ High cholesterol _____ Others _____

Blood Anemia _____ Low blood counts _____ Others _____

Neurologic Numbness _____ Tingling _____ Multiple sclerosis _____ Others _____

Immunologic Swollen glands _____ Infections _____

Autoimmune diseases (lupus, rheumatoid arthritis) _____ Others _____

Psychiatric Depression _____ Schizophrenia _____ Mania _____ Others _____