PROVIDENCE
Saint John's
Health Center

Reset Form

BRAIN TUMOR CENTER & PITUITARY DISORDERS PROGRAM AT SAINT JOHN'S

JOHN WAYNE CANCER INSTITUTE
at Providence Saint John's Health Center

PATIENT QUESTIONNAIRE

☐ Dr. Kelly
☐ Dr. Barkhoudarian

Name: _____ Date: _____

Your phone numbers: *Home:* _____ *Cell:* _____ E-Mail address: _____

Emergency Contact Person: _____ Phone number: _____

I came to see Dr. Kelly / Barkhoudarian by: ____ Referral from another physician (name): _____

____ Referral from a friend or another patient (name): _____

____ My own research (explain): _____

____ Other: _____

Prior to seeing Dr. Kelly / Barkhoudarian I went online and reviewed the BTC Website ☐ Yes ☐ No

Why are you seeing Dr. Kelly / Barkhoudarian? _____

What are your symptoms related to this problem?

1. _____ 3. _____
2. _____ 4. _____

Have you been diagnosed with other medical problems?

☐ High blood pressure _____ ☐ Heart disease (heart attack) _____
☐ High cholesterol / Hyperlipidemia _____ ☐ Diabetes _____
☐ Lung disease / Asthma _____ ☐ Thyroid _____
☐ Gastrointestinal problems _____ ☐ Kidney disease / dialysis _____
☐ Depression _____ ☐ Alzheimer's / Parkinson's disease _____
☐ Seizures _____ ☐ Stroke _____
☐ Pituitary / Hormone disorders _____ ☐ Brain tumor (benign or malignant) _____
☐ Cancer – type? _____ ☐ Other issues _____

Please list any past surgeries and the year performed:

1. _____
2. _____
3. _____

Which doctors need a copy of today's consultation note from Dr. Kelly / Barkhoudarian? Please provide phone and fax numbers.

1. _____ 3. _____
2. _____ 4. _____

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No If **YES** please list below:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: Do you have any allergies to medications? ☐ Yes ☐ No If **YES** please list below and describe reaction to medication:

1. _____ 3. _____
2. _____ 4. _____

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SOCIAL HISTORY

☐ Married ☐ Single ☐ Children? Number:_____

Are you currently employed? ☐ Yes ☐ No Current position? _____

Are you disabled? ☐ Yes ☐ No If YES, how long? _____

Do you drink alcohol? ☐ Yes ☐ No If YES, how often? _____

Do you smoke? ☐ Yes ☐ No If YES, how often? _____

FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

☐ Heart disease (heart attack)_____ ☐ High blood pressure _____

☐ Lung disease / Asthma_____ ☐ Kidney disease / dialysis _____

☐ Diabetes_____ ☐ Thyroid problem_____

☐ Depression_____ ☐ Alzheimer's / Parkinson's disease _____

☐ Seizures_____ ☐ Stroke _____

☐ Cancer – type?_____ ☐ Other issues _____

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

General

Y	N	Don't Know	
☐	☐	☐	Fever, chills, sweats
☐	☐	☐	Loss of appetite, weight loss

Eyes

Y	N	Don't Know	
☐	☐	☐	Eyes irritation / infection
☐	☐	☐	Glaucoma / cataract / eye surgery
☐	☐	☐	Wear glasses / contacts

ENT / Mouth

Y	N	Don't Know	
☐	☐	☐	Earache / ringing
☐	☐	☐	Sinusitis, runny nose, allergies
☐	☐	☐	Oral ulcerations

Respiratory

Y	N	Don't Know	
☐	☐	☐	Asthma, emphysema / bronchitis
☐	☐	☐	Cough
☐	☐	☐	Recent chest x-ray
☐	☐	☐	Tuberculosis

Cardiovascular

Y	N	Don't Know	
☐	☐	☐	Short of breath
☐	☐	☐	Irregular heartbeat

Psychiatric

Y	N	Don't Know	
☐	☐	☐	Depression
☐	☐	☐	Anxiety disorder

Gastrointestinal

Y	N	Don't Know	
☐	☐	☐	Nausea / vomiting
☐	☐	☐	Diarrhea / constipation / bloody stools
☐	☐	☐	Heartburn / indigestion / reflux disease
☐	☐	☐	Polyps / colonoscopy

Genitournary

Y	N	Don't Know	
☐	☐	☐	Increased urination
☐	☐	☐	Diarrhea / constipation / bloody stools

Musculoskeletal

Y	N	Don't Know	
☐	☐	☐	Leg cramps
☐	☐	☐	Arthritis / arthralgias / gout
☐	☐	☐	Soft tissue / bony trauma
☐	☐	☐	Congenital deformity

Skin

Y	N	Don't Know	
☐	☐	☐	Leg ulcers / discoloration of feet / legs
☐	☐	☐	Bruising / bleeding tendencies
☐	☐	☐	Acne

Reproductive

Y	N	Don't Know	
☐	☐	☐	Normal periods
☐	☐	☐	Absent periods
☐	☐	☐	Irregular periods
☐	☐	☐	Post-menopausal
☐	☐	☐	Pre-menopausal
☐	☐	☐	Hysterectomy

Please sign below:

Patient Signature: _____

Affix Patient Label Here

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