PROVIDENCE
Saint John's
Health Center

Reset Form

☐ Dr. Fuller
☐ Dr. Mahtabifard

The Cancer Center at Providence Saint John's Health Center
West Coast Associates for Minimally Invasive Thoracic Surgery

HEALTH QUESTIONNAIRE

DATE: _____

NAME: _____

AGE: _____

ADDRESS: _____

PHONE: _____

Which surgeon are you seeing today? (check one)

☐ **FULLER** ☐ **MAHTABIFARD**

Which of these risk factors for heart disease do you have?

- ☐ Smoker (either now or in the past)
- ☐ Diabetes
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Family history of heart disease

1. Chief Complaint:

What is the problem you are having that has brought you here to see the surgeon?

_____

_____

_____

2. Referral:

Who referred you to our office?

_____

_____

3. History of Present Illness:

Please answer the following questions about the problem you listed in question #1:

Where on your body is the problem located? _____

When did the problem start? _____

How often does it occur? _____

How long does the problem last? _____

Does it occur at a specific time of day? _____

What is the severity of the problem on a scale of 1-10? _____

Describe the quality of the problem? _____

What makes the problem better? _____

What makes the problem worse? _____

Is the problem associated with any other symptoms? If so, what are they? _____

Patient Name: _____

4. Review of Systems

Check any of the following that you have had:

Constitutional:	☐ Fever	☐ Weight loss	☐ Weight gain
Eyes:	☐ Glasses / contacts ☐ Glaucoma	☐ Double vision	☐ Cataracts
Ears, nose, throat:	☐ Impaired hearing ☐ Difficulty swallowing	☐ Sinus infections	☐ Nose bleeds
Chest:	☐ Breast cancer		
Cardiac:	☐ Heart attack ☐ Chest pain / angina ☐ High cholesterol	☐ Heart failure ☐ Palpitations ☐ Leg swelling	☐ High blood pressure ☐ Heart murmur
Respiratory:	☐ Shortness of breath ☐ Bronchitis	☐ Pneumonia ☐ Emphysema	☐ Asthma ☐ Tuberculosis
Gastrointestinal:	☐ Ulcer ☐ Gallbladder disease	☐ Hepatitis ☐ Bloody bowel movement	☐ Cirrhosis
Genitourinary:	☐ Incontinence ☐ Kidney stones	☐ Painful / difficult urination ☐ Kidney disease	☐ Bloody urine ☐ Dialysis
Vascular:	☐ Aneurysm ☐ Kidney artery disease	☐ Carotid artery disease	☐ Peripheral vascular disease
Musculoskeletal:	☐ Broken bone ☐ Pain calves while walking	☐ Osteoporosis	☐ Spine / back problems
Integumentary:	☐ Skin rash	☐ Jaundice	
Neurologic:	☐ Seizure	☐ Stroke	☐ Brain aneurysm
Hematological / Oncology:	☐ Bleeding disorder ☐ HIV / AIDS	☐ Anemia	☐ Cancer

Patient Name: _____

5. Past Medical / Family / Social History

List your medical problems	Date (year) they started

List surgeries you have had	Date (year) of surgery

Medications	Dose / Strength	How often do you take it?

Allergies:

_____

_____

_____

Patient Name: _____

Family History

Living Family Relatives

FAMILY MEMBER	CURRENT AGE	HEALTH PROBLEMS
Mother		
Father		
Brother(s) / Sister(s)		
Husband / Wife		
Son(s) / Daughter(s)		

Deceased Family Relatives

FAMILY MEMBER	CURRENT AGE	HEALTH PROBLEMS
Mother		
Father		
Brother(s) / Sister(s)		
Husband / Wife		
Son(s) / Daughter(s)		

Patient Name: _____

Social History

Marital Status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

What city do you live in? _____

With whom do you live? _____

Occupation? _____

Alcohol use: ☐ Never ☐ Occasionally ☐ Moderately ☐ Daily

If you use alcohol, what type of alcoholic beverage do you drink? _____

Tobacco use: Do you smoke? ☐ Yes ☐ No

If you smoke, when did you start smoking? _____

If you have quit, when did you quit? _____

How many packs do you smoke or did you smoke each day? _____