PROVIDENCE
Saint John's
Health Center

John Wayne Cancer Institute - Dermatology
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Reset Form

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

Medical Questionnaire **Date:** _____

Name: _____ Gender: ☐ Male ☐ Female Age: _____
Last First Middle

Birth-date:_____ Birth Place:_____ Mother's Birth Name: _____

Social Security #: _____-_____-_____ Driver's License #: _____

Marital Status: ☐ Single ☐ Married – Spouse's Name _____

Married how long? _____ ☐ Divorced ☐ Separated ☐ Widowed

Language Spoken:_____ Interpreter Required? ☐ Yes ☐ No

Home Address: _____

City: _____ State:_____ Zip-code:_____-_____

Phone: _____ Fax:_____

Employer:_____ Occupation: _____

Address:_____Phone:_____

City: _____ State:_____ Zip-code:_____-_____ Fax: _____

Emergency Contact: _____ Relationship:_____
(Not living in the same household)

Address:_____

City: _____State:_____Zip-code: _____Fax: _____

Local Telephone Number: (Relative, Friend or Hotel) _____

1. Primary Care Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State:_____ Zip-code:_____- _____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

2. Referring Physician (if other than #1): _____
   Specialty: _____
   Address: _____
   City: _____ State:_____ Zip-code:_____- _____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

3. Other Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State:_____ Zip-code:_____- _____
   Phone: _____ Fax: _____
   ☐ Send periodic report*

*** Periodic reports may be sent to your physician(s). Please check box of any physician you wish to receive reports.**

Patient Name: _____

Height:_____ Weight:_____

Allergies

Category	*Yes*	*No*	*Do Not Know*	*List Specific item (for example, sulfa, eggs, dust mites)*	*What happens (for example, rash, swelling, itchy eyes)?*
Drugs	☐	☐	☐		
Food	☐	☐	☐		
Environmental	☐	☐	☐		

Present Illness

Please describe in your own words the date of onset of your illness, symptoms & treatment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

How long have you had symptoms? Are they constant or do they come and go?

_____

What makes it worse?

_____

_____

_____

Has anything made it better?

_____

_____

_____

_____

Patient Name: _____

Please indicate if you have had or currently are experiencing any of the following. If you are not sure, please mark "Do Not Know" and we will be happy to assist you during your scheduled visit.

GENERAL

	Condition	Yes	No	Do Not Know
1.	Fever / Chills	☐	☐	☐
2.	Swollen or enlarged (lymph) glands	☐	☐	☐
3.	Weight Changes (loss or gain)	☐	☐	☐
4.	Night sweats (soaking the sheets)	☐	☐	☐
5.	Fatigue	☐	☐	☐
6.	Insomnia	☐	☐	☐
7.	Loss of appetite	☐	☐	☐

SKIN

	Condition	Yes	No	Do Not Know
1.	New or Changing moles	☐	☐	☐
2.	Birthmarks	☐	☐	☐
3.	New rashes	☐	☐	☐
4.	Sensitivity to the sun	☐	☐	☐

HEAD, EYES, EARS, NOSE, THROAT – (HEENT)

	Condition	Yes	No	Do Not Know
1.	Headaches	☐	☐	☐
2.	Dizziness or fainting spells	☐	☐	☐
3.	Vision problems / double or blurred vision	☐	☐	☐
4.	Problems with hearing	☐	☐	☐
5.	Sinus trouble	☐	☐	☐
6.	Nose bleeding	☐	☐	☐
7.	Sore tongue	☐	☐	☐
8.	Bleeding gums	☐	☐	☐
9.	Unusual trouble with teeth	☐	☐	☐
10.	Recent cold or sore throat	☐	☐	☐
11.	Itchy eyes, itchy nose (Allergies)	☐	☐	☐
12.	Dry eyes, Dry mouth	☐	☐	☐

ENDOCRINE

	Condition	Yes	No	Do Not Know
1.	Thyroid Problems	☐	☐	☐
2.	Heat or cold intolerance	☐	☐	☐
3.	Changes in hair or nails	☐	☐	☐
4.	Changes in skin texture	☐	☐	☐

Patient Name: _____

HEART

	Condition	Yes	No	Do Not Know
I.	Heart problems	☐	☐	☐
2.	Bruise easily or bleed easily	☐	☐	☐
3.	High blood pressure	☐	☐	☐
4.	Pressure in chest	☐	☐	☐
5.	Undue shortness in breath (day or night)	☐	☐	☐
6.	Ankle Swelling	☐	☐	☐
7.	Pain in legs while walking	☐	☐	☐
8.	Have you ever had a blood transfusion	☐	☐	☐

PULMONARY

	Condition	Yes	No	Do Not Know
1.	Chronic cough, coughed up blood	☐	☐	☐
2.	Do you have the date of your last chest x-ray?	☐	☐	☐
3.	Soaking sweats	☐	☐	☐
4.	Exposure to TB	☐	☐	☐
5.	History of a positive TB test (PPD)?	☐	☐	☐
6.	Asthma	☐	☐	☐

GASTROINTESTINAL

	Condition	Yes	No	Do Not Know
1.	Abdominal pain	☐	☐	☐
2.	Difficulty swallowing	☐	☐	☐
3.	Nausea or vomiting	☐	☐	☐
4.	Frequent bowel movements	☐	☐	☐
5.	Constipation	☐	☐	☐
6.	Recent change in bowel movements	☐	☐	☐
7.	Black bowel movements	☐	☐	☐
8.	Blood in stools	☐	☐	☐
9.	Jaundice	☐	☐	☐
10.	History of hepatitis?	☐	☐	☐
11.	Sensitivity to Gluten?	☐	☐	☐
12.	History of inflammatory bowel disease?	☐	☐	☐

GENITOURINARY URINARY

	Condition	Yes	No	Do Not Know
1.	Kidney problems	☐	☐	☐
2.	Blood in urine	☐	☐	☐
3.	Testicular pain / tenderness	☐	☐	☐

Patient Name: _____

MUSCULOSKELETAL / IMMUNE

	Condition	Yes	No	Do Not Know
1.	Joint pain / arthritis	☐	☐	☐
2.	Back or bone pain	☐	☐	☐
3.	Numbness or tingling of hands or feet	☐	☐	☐
4.	Muscle pain or weakness, sore muscles	☐	☐	☐
5.	Muscle spasms	☐	☐	☐
6.	History of autoimmune disease	☐	☐	☐
7.	Abnormal antibody tests?	☐	☐	☐
8.	Immune problems	☐	☐	☐
9.	Color changes in fingers / toes (white, blue or red)	☐	☐	☐

NEUROLOGIC

	Condition	Yes	No	Do Not Know
1.	Excessive worry	☐	☐	☐
2.	Excessive depression	☐	☐	☐
3.	Nervous disorders	☐	☐	☐
4.	Slowed thinking, decreased concentration or decreased memory (out of ordinary)	☐	☐	☐
5.	Seizures	☐	☐	☐
6.	Tremors	☐	☐	☐
7.	Strokes	☐	☐	☐
8.	Trans Ischemic Attack (TIA)	☐	☐	☐
9.	Changes in your vision	☐	☐	☐
10.	Problems with bowel / bladder control	☐	☐	☐
11.	Unsteady walking	☐	☐	☐
12.	Loss of balance	☐	☐	☐
13.	Headaches	☐	☐	☐

Habits

	Condition
1.	Alcohol intake: ☐ Yes ☐ No Indicate next to each the amount of drinks and Frequency- i.e. Daily, Weekly or Monthly. 1. Beer _____ 2. Wine _____ 3. Whiskey _____ 4. Other _____
2.	Smoking: Cigarettes _____ packs_____
3.	Intravenous Drug use? ☐ Yes ☐ No
4.	Other Drug use? (such as freebase cocaine) ☐ Yes ☐ No
5.	Exercise ☐ Yes ☐ No If yes, type and frequency?

Patient Name: _____

Past Surgeries (Operations):
Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Other Hospitalizations:
Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

Please list any medications / herbs / supplements you are taking, date that you started and the date you discontinued (if applicable).

Pain Pills:
Tranquilizers:
Sleeping Pills:
Antibiotics (recently):
High blood pressure medicine / water pills:
Medicine for cholesterol control:
Over the counter / non-prescription drugs / nutritional supplements (i.e. Aspirin, Tylenol, Motrin, Aleve, Vitamins, Diet Pills, herbs, etc.):
Other Medications:

Patient Name: _____

Family History

RELATION	AGE	STATE OF HEALTH	IF DECEASED – CAUSE OF DEATH	AGE AT DEATH
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Patient Name: _____

Fitzpatrick Skin-Type
Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Grey, Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy red	Blond	Chestnut / Dark Blond	Dark Brown	Black
What is the color of your skin (non sun-exposed areas)?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Patient Name: _____

Fitzpatrick Classification Scale

Skin Type	Skin Color	Characteristics
I	White; very fair; red or blond hair; blue eyes: freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	Very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

Patient Name: _____

Recent Travel:

Dates	Location	Unusual exposures

Certain diseases are more common in specific genetic backgrounds. Please indicate your ethnicity:

- ☐ Caucasian
- ☐ Black or African American
- ☐ Non-African Black
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic / Latino
- ☐ Other: _____

Have any of your *blood* relatives, husband, wife or children had any of the following?

Yes	No	(CHECK EACH ITEM)	RELATION(S)
☐	☐	Tuberculosis	
☐	☐	Diabetes	
☐	☐	Cancer (Melanoma, Basal cell, Squamous cells, Merkel or other)	
☐	☐	Autoimmune disease (Lupus, Dermatomyositis, Vitiligo, Pemphigus, Pemphigoid, Scleroderma)	
☐	☐	Unusual moles (Atypical Nevus Syndrome, Giant Congenital Nevus)	
☐	☐	Kidney Disease	
☐	☐	Asthma, Hay Fever, Other Allergy	
☐	☐	Chronic Arthritis (Rheumatism)	
☐	☐	Multiple Sclerosis or Guillan Barre Syndrome	
☐	☐	Nervous Or Mental Disorder	
☐	☐	Any Other Illness (please specify):	