PROVIDENCE
Saint John's
Health Center

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

MARGIE PETERSEN BREAST CENTER

Medical History Questionnaire

Date: ____________________

Name: ______________________________________ Sex: ☐ Female ☐ Male
Last First Middle

Date of Birth: ____________________ Age: ________ Birth Place: ____________________

Mother's Birth Name: ____________________ Social Security #: _______-_______-_______

Marital Status: ☐ Single ☐ Married/Partnered (how long)________ ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ White/Caucasian ☐ Black/African-American ☐ Native Hawaiian or other Pacific Islander
☐ Ashkenazi Jewish Heritage ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic/Latina
☐ Other: ____________________

Home Address: ____________________

Home Phone: (________) ____________________ Driver's License #: ____________________

Cell Phone: (________) ____________________ Email: ____________________

Employer/Business Name: ____________________ Occupation: ____________________

Business Address: ____________________

Business Phone: (________) ____________________ If retired or disabled, since when? ____________

Emergency contact: ____________________ Relationship: ____________________

Address: ____________________ Phone: (________) ____________________

Please provide your physicians' information below so that we may send reports:

Referring Physician:

1) Name: ____________________ Phone: (________) ____________________
Address: ____________________

Other Physicians:

2) Name: ____________________ Phone: (________) ____________________
Address: ____________________

3) Name: ____________________ Phone: (________) ____________________
Address: ____________________

Who is to be billed for your consultation and treatment?
☐ Insurance 1 ____________________ ☐ Insurance 2 ____________________ ☐ Self-Pay

We would like to know how you selected the **Margie Petersen Breast Center at Providence Saint John's Health Center:**

- ☐ My physician recommended I come
- ☐ I asked my physician to refer me
- ☐ I referred myself
- ☐ A friend or relative referred me
- ☐ Other: ____________________

Patient Name: ____

History of your present health problem or illness for which you are seeking care at the Margie Petersen Breast Center at Providence Saint John's Health Center:

Please describe briefly, in your own words, the date of onset of your current problem or illness, any symptoms you have experienced, and the dates of any tests and/or treatment(s), with the names and addresses of physicians whom you have consulted.

Patient Name: ____

Do you now have or have you ever had any of the following?

	Condition	Yes	No	Do Not Know
1.	Epilepsy	☐	☐	☐
2.	Headaches	☐	☐	☐
3.	Dizziness or fainting spells	☐	☐	☐
4.	Eye injuries	☐	☐	☐
5.	Double vision	☐	☐	☐
6.	Blurred vision	☐	☐	☐
7.	Eye pain	☐	☐	☐
8.	Cataracts	☐	☐	☐
9.	Glaucoma	☐	☐	☐
10.	Earaches	☐	☐	☐
11.	Ringing or buzzing in ear	☐	☐	☐
12.	Decrease or loss of hearing	☐	☐	☐
13.	Sensation of spinning	☐	☐	☐
14.	Sinus trouble	☐	☐	☐
15.	Nose bleeding	☐	☐	☐
16.	Sore tongue	☐	☐	☐
17.	Unusual trouble with teeth	☐	☐	☐
18.	Skin disease	☐	☐	☐
19.	Skin tumors or moles removed or burned	☐	☐	☐
20.	Diabetes	☐	☐	☐
21.	Thyroid trouble or goiter	☐	☐	☐
22.	Thyroid tests or medication	☐	☐	☐
23.	Frequent laryngitis	☐	☐	☐
24.	Hoarseness or change in voice	☐	☐	☐
25.	Bleeding gums	☐	☐	☐
26.	Bleeding tendency or easy bleeding/bruising	☐	☐	☐
27.	Other tumors or cancer	☐	☐	☐
28.	Tuberculosis	☐	☐	☐
29.	Mumps	☐	☐	☐
30.	Rheumatic fever	☐	☐	☐
31.	Scarlet fever	☐	☐	☐
32.	Venereal disease	☐	☐	☐
33.	Swollen or enlarged (lymph) glands	☐	☐	☐
34.	Lumps in breast	☐	☐	☐
35.	Pain in breast	☐	☐	☐
36.	Nipple discharge	☐	☐	☐
37.	Heart disease	☐	☐	☐
38.	High blood pressure	☐	☐	☐
39.	Pain or pressure in chest	☐	☐	☐
40.	Undue shortness of breath (day or night)	☐	☐	☐
41.	Ankle swelling	☐	☐	☐
42.	Pain in legs while walking	☐	☐	☐

Patient Name: ____

Do you now have or have you ever had any of the following?

	Condition	Yes	No	Do Not Know
43.	Fast or irregular heartbeat (palpitations)	☐	☐	☐
44.	Heart murmurs	☐	☐	☐
45.	Chronic cough, coughing up blood	☐	☐	☐
46.	When was your last X-ray? Mo/Yr________________________________ ☐ Never	☐	☐	☐
47.	Soaking sweats	☐	☐	☐
48.	Asthma	☐	☐	☐
49.	Excessive worry or depression	☐	☐	☐
50.	Nervous disorders	☐	☐	☐
51.	Stomach, liver, or intestinal trouble	☐	☐	☐
52.	Recent gain or loss of weight ☐ Gained ________lbs ☐ Lost ________lbs	☐	☐	☐
53.	Decreased appetite	☐	☐	☐
54.	Difficulty swallowing	☐	☐	☐
55.	Nausea or vomiting	☐	☐	☐
56.	Indigestion or heartburn	☐	☐	☐
57.	Gallbladder disease	☐	☐	☐
58.	Hepatitis	☐	☐	☐
59.	Cirrhosis	☐	☐	☐
60.	Frequent bowel movements	☐	☐	☐
61.	Constipation	☐	☐	☐
62.	Recent change in bowel movements	☐	☐	☐
63.	Black bowel movements	☐	☐	☐
64.	Blood in stools	☐	☐	☐
65.	Jaundice	☐	☐	☐
66.	Kidney trouble	☐	☐	☐
67.	Frequent or painful urination	☐	☐	☐
68.	Kidney stones or blood in urine	☐	☐	☐
69.	Sugar or albumin in urine	☐	☐	☐
70.	Slow starting of urine stream	☐	☐	☐
71.	Passing urine at night	☐	☐	☐
72.	Arthritis or rheumatism	☐	☐	☐
73.	Back or bone pain	☐	☐	☐
74.	Clumsiness or awkwardness of hands or feet	☐	☐	☐
75.	Numbness or tingling of hands or feet	☐	☐	☐
76.	Muscle pain or weakness	☐	☐	☐
77.	Forgetfulness	☐	☐	☐
78.	Nervous disorders	☐	☐	☐
79.	Any reactions to serum, drug or medicine	☐	☐	☐
80.	Unusual fatigue	☐	☐	☐
81.	Insomnia, sleep problems	☐	☐	☐
82.	**(MEN)** Sexual impotence	☐	☐	☐
83.	Daily alcohol intake: beer______ wine______ liquor______ other:______________	☐	☐	☐
84.	Smoke cigarettes. If yes, __________ packs per day	☐	☐	☐

Patient Name: ____

Women Only:

Do you now have or have you ever had any of the following?

	Condition	Yes	No	Do Not Know
85.	Vaginal bleeding after intercourse	☐	☐	☐
86.	Painful menstruation	☐	☐	☐
87.	Irregular or excessive menstruation	☐	☐	☐
88.	Vaginal discharge	☐	☐	☐
89.	Been treated for a female disorder	☐	☐	☐
90.	Intrauterine device (IUD)	☐	☐	☐
91.	Gone through menopause	☐	☐	☐

Past breast problems (list):

Right/Left Side Type of Problem When

____

____

____

____

____

____

Have you ever taken hormones? ☐ Yes ☐ No ☐ Don't Know If yes, which ones and for how long?

Hormone	**When started?**	**When stopped?**
Birth Control Pills		
Estrogen		
Tamoxifen		
Evista (Raloxifene)		
Other:		

Age of onset of menstruation: ____

Interval between periods: ____

Duration of periods: ____

Date of last period: ____

Number of pregnancies: ____

Number of births: ____

Number of miscarriages: ____

Number of abortions: ____

Age at first childbirth: ____

Family history of breast problems: ____

____

____

____

Patient Name: ____

Past Surgery (Operations):
Please list in chronological order

MONTH	YEAR	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Chronic Medical Problems:

DESCRIPTION	YEAR DIAGNOSED	TREATMENT	DOCTOR

Other Hospitalizations:
Please list in chronological order

MONTH	YEAR	TYPE	HOSPITAL	DOCTOR

Patient Name: ____

Are you allergic to any medicines? ☐ Yes* ☐ No

*Please list any medications to which you have had an allergic reaction, and the type of reaction:

____

____

____

Are you allergic to any foods? ☐ Yes* ☐ No

*Please list any foods to which you have had an allergic reaction, and the type of reaction:

____

____

____

Please list any medications you are now taking:

	Name of Medication	**Dosage**	**Frequency**
Hormones or Birth Control Pills:			
Antidepressant/Antianxiety Pills:			
Tranquilizers/Sleeping Pills:			
Pain Pills:			
Other:			

Please list or describe any other therapies, vitamins, or herbal remedies you are taking currently, why & how you take each (such as frequency and amount): ***(if you need more space, please continue on the back)***

Name of Vitamin, Herb or Therapy	**Purpose**	**Dosage & Frequency**	**When Started**

Past Radiation Therapy Treatment:

Please list in chronological order.

We need to know when treatment started and when it was completed.

STARTED?		STOPPED?		AREA OF BODY TREATED	HOSPITAL	DOCTOR
Month	Year	Month	Year			

Patient Name: ____

Family History

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

Patient Name: ____

Family History (continued)

Have any of your blood relatives (both mother's and father's sides), spouse, or children had:

Yes	No	(CHECK EACH ITEM)	RELATION(S)
☐	☐	Tuberculosis	
☐	☐	Diabetes	
☐	☐	Cancer ☐ Breast............ ☐ Ovarian............ ☐ Colon............ ☐ Prostate............ ☐ Other............	
☐	☐	Leukemia	
☐	☐	Anemia	
☐	☐	Bleeding Tendency	
☐	☐	Heart Disease	
☐	☐	High Blood Pressure	
☐	☐	Kidney Disease	
☐	☐	Asthma, Hay Fever, Other Allergy	
☐	☐	Chronic Arthritis (Rheumatism)	
☐	☐	Nervous Or Mental Disorder	
☐	☐	Goiter	
☐	☐	Emphysema	
☐	☐	Any Other Illness	