Document Type: Forms/Other

MSC077

METHODIST HOSPITAL

HEAD AND NECK ONCOLOGY

Room #_____

MEDICAL HISTORY QUESTIONNAIRE

What are you being seen for: _____

How long have you had this problem: _____

Referring Physician: _____

Please list other physicians that you would like a report sent to regarding your visit: _____

PAST MEDICAL HISTORY

Please list all current medical problems:

Please list all surgeries (year):

******** FOR CLINIC USE ********

WT LB_____ KG_____

BP _____ HEIGHT_____

PULSE_____ TEMP_____

DENTIST_____

DENTAL

Teeth Yes No

Dentures Yes No

Full Set Upper Lower Both

Partials Upper Lower Both

Have you previously received chemotherapy? If yes, Diagnosis:_____ Year:_____

Facility: _____ City/State:_____ Treating Physician:_____

Have you previously received radiation therapy? If yes, Diagnosis:_____ Year:_____

Facility: _____ City/State:_____ Treating Physician:_____

MEDICATIONS

Please list **ALL** Current Medication:
Including: *prescription, over the counter, birth control, vitamins, etc.*

MEDICATION	DOSE / FREQUENCY

ALLERGIES

Please list **ALL** Medication/Food Allergies.
Do you have a **LATEX** allergy? Yes___ No ___

MEDICATION / FOOD	REACTION

PHARMACY: _____ CITY, STATE:_____ PHONE#:_____

Please complete back of form

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

NMHS-2030
Rev. 8/2021

METHODIST HOSPITAL

HEAD AND NECK ONCOLOGY

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

What type of work do you do? _____

Do you use tobacco products? No ___ When did you quit _____ Yes ___ Type / amount / how long:_____
Do you drink alcohol? No ___ When did you quit _____ Yes ___ Type / amount / how long:_____
Do you use illegal drugs? No ___ When did you quit _____ Yes ___ Type / amount / how long:_____

Have you been exposed to or tested positive for (Yes/No): Human Papilloma Virus (HPV)___ Gonorrhea___ HIV___ Hepatitis ___A / B / C
Do you have implants, such as artificial heart valves or hip prosthesis? YES ___ NO ___
Have you ever been told to take antibiotics, prior to surgery, because of a heart condition? YES ___ NO ___

REVIEW OF SYSTEMS Do you have any problems in the following areas. Please circle Yes (Y) or No (N) and underline one that applies.

Constitutional
Night Sweats Y N
Recurrent Fevers Y N
Your weight 1 month ago _____ lbs
Your weight 6 months ago _____ lbs

Eyes
Double vision Y N
Injuries Y N
Dryness Y N
Wear glasses or contacts Y N

Ears, Nose, Mouth, Throat
Sinus Congestion Y N
Runny or Bloody nose Y N
Post-Nasal Drip Y N
Hearing Loss Y N
Dry Throat / Mouth Y N
Difficulty / Pain with eating Y N

Nutrition / Food Intake
I can eat anything without difficulty Y N
I can eat hard & crunchy foods Y N
I only eat soft foods Y N
I drink liquids, very little solid food Y N
I only drink liquids, no solid food Y N

Cardiovascular
Chest Pain or Angina Y N
Heart Murmur Y N
Vascular Disease Y N

Respiratory
Asthma Y N
Chronic Cough Y N
Shortness of Breath Y N
Bloody Sputum Y N

Musculoskeletal
Muscle Pain / Weakness Y N
Joint Pain Y N

Gastrointestinal
Constipation / Diarrhea Y N
Chronic Nausea / Vomiting Y N
Abdominal Pain Y N

Genitourinary
Blood in Urine Y N
Difficulty Urinating Y N

Neurologic
Fainting Spells or Blacking Out Y N
Difficulty with your speech Y N
Frequent Headaches or Migraines Y N
Seizures

Psychiatric
Anxiety Y N
Depression Y N
Feeling Suicidal Y N
Other Psychiatric Issues or Treatment?

Endocrine
Hormone Problems Y N
Pregnant or nursing Y N

Integumentary
Skin Cancer Y N
Skin Disease Y N

Lymphatic / Hermatologic
Anemia Y N
Bleeding Problems Y N
Persistent Swollen Glands/Nodes Y N
Blood transfusions (when_____) Y N

FAMILY HISTORY (Parents, Grandparents, Siblings, Children; Living or Deceased) Please not for the following medical conditions:

Arthritis	Asthma	Strokes TIAs	Birth Defects
Diabetes	Pulmonary Disease	Migraines	Immune Disorders
High Blood Pressure	Thyroid Disease	Bleeding Disorders	Kidney Disease
Heart Disease / Attacks	Tuberculosis	Problems with Anesthesia	Hearing Impairment

Cancer – type: _____
Other-explain: _____

_____ _____ _____
Patient/Legal Guardian/Surrogate Decision Maker Signature | Date | Relationship to Patient

_____
Patient/Legal Guardian/Surrogate Decision Maker Printed Name

****

FOR CLINIC USE ONLY:_____

_____

_____

_____

_____ _____
Medical Staff Reviewing | Nursing Staff

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD