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?_____

Referring Physician (First and last name): _____

Primary Care Physician (First and last name): _____

Dentist (First and last name): _____

MEDICAL PROBLEMS (ex: high blood pressure, diabetes, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS SURGERIES / YEAR

_____ / _____

_____ / _____

_____ / _____

_____ / _____

_____ / _____

_____ / _____

_____ / _____

_____ / _____

Have you had any of the following cancers? (circle all that apply): Head and neck cancer Thyroid cancer Skin cancer Leukemia/lymphoma Other cancers:_____

What year(s) were you diagnosed? _____

Have you had any of the following treatments for cancer? (circle all that apply):

Surgery Radiation Chemotherapy Other:_____

Treatment facility name(s):_____ Locations (city, state)_____

Treating physicians first and last names: _____

MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS
Including: prescription, over the counter, birth control, vitamins, etc.

MEDICATION NAME	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. 9/2021

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.
Employment status:_____Full-time ____Part-time ____Retired ____ On disability ____Stay at home ____Looking for work
What type of work do you do / have you done? _____

Tobacco Use: _____Current _____Never _____Former (Year You Quit_____) What type(s)? _____cigarettes _____cigars _____vape _____chew
How much do/did you use per day (average)?_____/ How many years? _____

Do you drink alcohol currently? _____Yes _____No How many drinks per week (1 drink = 12oz beer, 5oz wine, 1.5oz liquor)?_____
Have you ever had a drinking problem? _____Yes _____No When did you quit (if no longer using)?_____

Recreational drugs: _____Current _____Never _____Former (Year You Quit_____) Type of drugs? _____

Do you have a "pain contract" with a physician? _____Yes _____No Do you have objections to blood transfusions? _____Yes _____No
Do you make health care decisions for yourself? _____Yes _____No Do you have an advanced directive/living will? _____Yes _____No
Do you need help with daily activities (bathing, eating, walking, getting dressed, etc.)? _____No _____Sometimes _____Often
What is your mobility? _____Walk without help _____Walk with a cane/walker _____Mostly wheelchair _____Unable to walk at all

Living conditions: _____House/Apartment by myself _____House/Apartment with others _____Homeless _____Facility
Facility name:_____ Facility phone#:_____

Are you pregnant? _____Yes _____No Are you nursing? _____Yes _____No

REVIEW OF SYSTEMS: Have you had any of these problems in the last several weeks? Please circle Yes (Y) or No (N).

Constitutional/Whole Body		**Heart and Lung**		**Neurologic/Psychiatric**	
Night sweats	Y N	Chest Pain / angina	Y N	Frequent Headaches	Y N
Recurrent fevers	Y N	Vascular / artery disease	Y N	Anxiety	Y N
Unintentional weight loss	Y N	Coughing up blood	Y N	Depression	Y N
_____lb over _____months		Chronic Cough	Y N	Feeling suicidal	Y N
		Shortness of Breath	Y N	Other Psychiatric Issues or Treatment?	
Eyes, Ears, Nose, Mouth, Throat				_____	
Double vision	Y N	**Muscles/Joints/Skin**			
Sinus congestion	Y N	Skin disease / type_____	Y N	**Gastrointestinal**	
Bloody nose	Y N	Muscle weakness	Y N	Diarrhea	Y N
Hearing loss	Y N	Joint Pain	Y N	Nausea / vomiting	Y N
Dry throat / mouth	Y N			Abdominal pain	Y N
Difficult / painful swallowing	Y N	**Endocrine/Hormones**		Reflux / heartburn	Y N
Hoarseness	Y N	Parathyroid disease	Y N	Constipation	Y N
Do you have a feeding tube?	Y N	Thyroid disease	Y N		
		Diabetes	Y N	**Hematologic**	
Genitourinary				Bleeding problems	Y N
Kidney stone	Y N	**Problems with Anesthesia**	Y N	Anemia	Y N
Human papillomavirus (HPV)	Y N			Clotting disorders	Y N

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

Diabetes	Stroke	Problems with anesthesia	Thyroid / Parathyroid disease
High blood pressure	Lung disease	Immune disorders	Bleeding / Clotting disorders
Heart disease / attacks	Kidney disease	Cancers: Who/Type:_____	

Other: _____

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

_____
Patient/Legal Guardian/Surrogate Decision Maker Printed Name

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FOR CLINIC USE ONLY: Teeth? ____Yes ____No___ Dentures? _____Full ____Partial _____None MRSA (+)_____ VRE (+)_____
Weight_____lb_____kg BP_____/_____ Pulse_____bpm Temp_____C / F pain (1-10)_____ Height_____cm / in

_____
_____
_____

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD