BARBARA ANN Karmanos
CANCER INSTITUTE
Wayne State University

Health History Questionnaire

- Complete this form as best as you can. Completing it prior to your appointment will save 30-45 minutes.
- You can save even more time by filling the form out online at www.karmanos.org and clicking the "Make an Appointment" on the top right side of the page.
- Your answers help us assess your case and also help in making recommendations
- For assistance, please call 1-800-KARMANOS (1-800-527-6266).

Personal Information

Your Last Name | First Name | Middle Initial | Age

Street Address/Apt. No. | City | State | Zip

( ) Home Phone | ( ) Work Phone | ( ) Cell/Mobile Phone

Social Security Number | Date of Birth | E-mail Address

Emergency Contact Information

Contact's Last Name | First Name | Middle Initial | Relationship

Street Address/Apt. No. | City | State | Zip

( ) Home Phone | ( ) Work/Cell Phone | E-mail Address

Physician Information

How were you referred to the Karmanos Cancer Institute? ☐ Physician ☐ Self/Other

If referred by physician, date referred to the Karmanos Cancer Institute: _____

Physician's Last Name | First Name | Middle Initial

Street Address/Suite | City | State | Zip

( ) ( )
Office Phone | Fax | E-mail Address

Do you have a primary care physician? ..... ☐ Yes ☐ No

Physician's Last Name | First Name | Middle Initial

Street Address/Suite | City | State | Zip

( ) ( )
Office Phone | Fax | E-mail Address

Does your insurance require referrals for office visits and/or tests? ……... ☐ Yes ☐ No

List all other physicians who should receive results of your consultation at Karmanos:

Physician's Last Name | First Name | Middle Initial

Street Address/Suite | City | State | Zip

( ) ( )
Office Phone | Fax | E-mail Address

What is your race?

____American Indian or Native American ____Middle Eastern ____Asian
____Native Hawaiian or Pacific Islander ____White ____Black or African American ____Unknown ____Other ____Decline to answer

What is your ethnicity?

____Hispanic or Latino ____Non-Hispanic ____Unknown
____ Decline to answer

Medical History: Cancer

Describe (in your own words) how your illness started and what test(s) you had done before your appointment at the Karmanos Cancer Institute

Surgery

Have you ever had cancer surgery? If "yes," describe below ……..□ Yes □ No

Month/Year	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after surgery:

Radiation Therapy

Have you ever had radiation therapy? If "yes," describe below ……..... □ Yes □ No

Start - End Date	Area of Body Treated	Hospital	Physician
–			
-			
–			
–			

Describe any problem(s) you experienced during or after radiation therapy:

Chemotherapy

Have you ever had chemotherapy? If "yes," describe below…….□ Yes □ No

Start - End Date	Chemotherapy	Hospital	Physician
–			
-			
–			
–			

Describe any problem(s) you experienced during or after chemotherapy:

Medical History: Non-Cancer

How was your health before your diagnosis? ..... □Excellent □Good □ Fair □ Poor
How do you feel right now? ..... □Excellent □Good □ Fair □ Poor

Medical Illnesses or Conditions: List all non-cancer illnesses or conditions (for example, diabetes, heart disease, high blood pressure, etc.) starting with most recent.

Illness/Condition	Date	Treatment	Physician

Hospitalizations & Operations: List all non-cancer hospitalizations and operations.

Reason for	Date(s)	Hospital	Physician

Medications: List all medications and doses you are now taking (including vitamins and nonprescription drugs. **Bring all medications to your first visit.**

Medication	Date	Dosage	Frequency

Medical Allergies	**Yes**	**No**	**Don't Know**
Are you allergic to the dye used in X-rays?			
Are you allergic to latex?			
Are you allergic to medications (for example, Penicillin)?			

Medication	Date of Reaction	Type of Allergic Reaction

Family Health History

Include only blood relatives, whether or not they have been diagnosed with cancer. Do not include anyone adopted, foster, step-relatives or those related by marriage. List current age or age at time of death.

Relative	Age	Alive?		Had Cancer?		If "Yes", List Types (breast, lung)	Died of cancer?		Other Medical Problems?		If "Yes," List Conditions (heart disease, kidney failure)
		Yes	No	Yes	No		Yes	No	Yes	No	
Your Mother											
Your Father											
Your Mother's Mother											
Your Mother's Father											
Your Father's Mother											
Your Father's Father											
Your Daughter 1											
Your Daughter 2											
Your Daughter 3											
Your Daughter 4											
Your Son 1											
Your Son 2											
Your Son 3											
Your Son 4											
Your Sister 1											
Your Sister 2											
Your Sister 3											
Your Sister 4											
Your Brother 1											
Your Brother 2											
Your Brother 3											
Your Brother 4											
Other											

Other illnesses that "run" in your family:

Social History	Yes	No	Don't Know
Marital status: ___Married ___Single ___Separated ___Divorced ___Widowed			
Number of dependents at home:			
Education: ___Grade school ___High school ___College ___Other			
Main language: ___English ___Spanish ___Arabic __Other			
Need a translator?			
Have reliable transportation to medical appointments?			
Have insurance coverage for prescription drugs?			
Have advanced directive/durable power of attorney? (If "yes," bring to visit.)			
Have family/friends to help you during your treatment?			
Have emotional support from family members/friends?			
Have someone living with you?			
If "yes," name: Phone: ( )			
Need help coping with your diagnosis?			
If "yes," are you receiving help?			
If "yes," name: Phone: ( )			
Does your family need help coping with your diagnosis?			
Would you like to speak to someone for emotional support?			
Are you currently being abused physically, sexually or emotionally?			

Occupation/Work History & Environmental Exposure	Yes	No	Don't Know
What is your current occupation?			
Did you previously have a different occupation?			
Were you ever exposed to the following (work or elsewhere):			
Asbestos			
Chronic Fumes			
Chronic Dust			
Radiation			
Toxic Chemicals			
Other (list)			

Tobacco, Alcohol & Other Substance Use			
Have you used ___cigarettes ___cigars ___pipe ___chewing tobacco ___snuff (check all that apply)			
How much do/did you use per day? Number of years? ____			
Are you still using? ____ Yes/No			
When did you stop? _____	Yes	No	Don't Know
Have you been exposed to secondhand smoke at home or work?			
Do you drink alcoholic beverages regularly? How much?_____			
Do you drink alcoholic beverages on social occasions only?			
Has alcohol ever interfered with your personal/professional life?			
Did you, or do you, use marijuana?			
Have you used cocaine, heroin or other illegal substances?			

If you are currently experiencing — or previously experienced — any of the following to a significant degree, explain on a separate page.

General	Yes within 3 months	Yes more than 3 months ago	No
Fever			
Sweats			
Weakness			
Fatigue			
Weight Loss			

Pain	Level
Average pain most days:	0 1 2 3 4 5 6 7 8 9 10 (none/low) (worst)
Where does it hurt?	
Staying the same or getting worse?	____Same ____Worse
What are you taking for it?	

	Yes	No	
Does this help?			

Skin	Yes within 3 months	Yes more than 3 months ago	No
Excessive sun exposure			
Blistering/burns			
Use sunscreen			
Dark or pigmented skin lesion			
Dark or pigmented skin lesion removed			
Melanoma			
Bleeding skin lesion			
Skin cancer			
Psoriasis			
Chronic rash			
Vitiligo			
Birthmark			
Family member with dysplastic nevus syndrome			

Eyes	Yes within 3 months	Yes more than 3 months ago	No
Lost vision			
Wear glasses			
Cataracts			
Glaucoma			

Ears	Yes within 3 months	Yes more than 3 months ago	No
Lost hearing			
Ringing in your ears			

Sinuses	Yes within 3 months	Yes more than 3 months ago	No
Sinus trouble			
Nosebleeds			

Mouth	Yes within 3 months	Yes more than 3 months ago	No
Dental problems			
Wear dentures			
Sore tongue			

Neck	Yes within 3 months	Yes more than 3 months ago	No
Swollen glands			
Laryngitis			
Hoarseness			

Breast	Yes within 3 months	Yes more than 3 months ago	No
Breast biopsy			
Breast cancer			
Nipple discharge			
Breast lumps			
Cystic breast disease			
Breast infection			
Mammogram			
Hormone replacement therapy			
Breastfed any children			
If “yes,” how long in total months:			

Lungs	Yes within 3 months	Yes more than 3 months ago	No
Cough every day			
Cough, produce sputum (phlegm) most days			
Blood in your sputum			
Pneumonia			
Bronchitis			
Emphysema			
Pleurisy			
Tuberculosis			
Asthma			
Short of breath with activity			
Short of breath at rest			
Frequent colds			

Heart, Blood Vessels	Yes within 3 months	Yes more than 3 months ago	No
Chest pain (Angina)			
Chest pressure			
Heart attack			
Short of breath at night			
Heart murmur			
Rapid heartbeat that required treatment			
Swollen ankles			
Leg cramps at night			
Leg cramps when walking			
Rheumatic fever			
Congenital heart disease			

Endocrine/Glands	Yes within 3 months	Yes more than 3 months ago	No
Diabetes mellitus			
Thyroid disease			
Other endocrine/ gland conditions (list)			

Gastrointestinal	Yes within 3 months	Yes more than 3 months ago	No
Lost appetite			
Recent weight change			
If yes, amount: _____Loss _____Gain			
Excess saliva			
Swallowing problems			
Difficult			
If yes, date started:			
Solids stick			
If yes, where:			
Pain			
If yes, date started:			
Choking			
Food comes out your nose			
Heartburn			
Ulcer			
Endoscopy (upper GI, colonoscopy, etc.)			
Nausea			
Vomiting			
Vomit blood			
Diarrhea			
Upset stomach (food related)			
Constipation			
Black bowel movements			
Bloody bowel movements			
Yellow or jaundiced			
Hepatitis			
Gall bladder problems			
Cirrhosis			

Genitourinary	Yes within 3 months	Yes more than 3 months ago	No
Kidney problems			
Frequent urination			
Painful urination			
Urinate at night			
Blood in urine			
Kidney stones			

Genitourinary: Men	Yes within 3 months	Yes more than 3 months ago	No
Difficulty starting stopping urination			
Sexual performance problems			
Elevated prostate blood test (PSA)			
Prostate biopsy			
Swollen/painful testicle			

Genitourinary: Women	Yes within 3 months	Yes more than 3 months ago	No
Age started menstruating:			
Irregular or painful menstruation			
Still menstruating			
Date of last menstrual period:			
Age stopped menstruating:			
Painful intercourse			
Bleeding following intercourse			
Endometriosis			
Did your mother take estrogens when pregnant with you?			
Date of your last pap smear:			
Pregnant now			
Number of pregnancies:			
Number of children:			
Number of miscarriages:			
Age at first pregnancy:			
Age at first live birth:			

Neurological	Yes within 3 months	Yes more than 3 months ago	No
Dominant hand: ____Right _____Left			
Headaches			
Seizure			
Double vision			
Blurred vision			
Weakness in extremity			
Numbness			
Stroke			
Migraine headache			
Forgetfulness			
Confusion			

Hematologic	Yes within 3 months	Yes more than 3 months ago	No
Blood transfusion			
Rejected as blood donor			
Bruise or bleed easily			
Anemic			
Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alleve)			
Swollen glands			

Extremities & Back	Yes within 3 months	Yes more than 3 months ago	No
Arthritis			
Back pain			
Broken bone			
Swollen joints			

Activities you find difficult	Yes within 3 months	Yes more than 3 months ago	No
Bathing			
Dressing			
Eating			
Housekeeping			
Using toilet			
Walking			

Questions you may have:

Patient Signature Date

Patient's Representative's Signature/Relationship Date

Reviewed by Date

Reviewed by Date

Reviewed by Date