

MARGIE PETERSEN BREAST CENTER
John Wayne Cancer Centers
at Saint John's Health 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 #: _____

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 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: _____

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

	YES	NO	DON'T 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			

	YES	NO	DON'T KNOW
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			

	YES	NO	DON'T KNOW
42. Pain in legs while walking			
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			

	YES	NO	DON'T KNOW
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			

	YES	NO	DON'T KNOW
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			

Women only:

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

	YES	NO	DON'T 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: _____

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

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			

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					

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	