East Hawaii Health
1285 Waianuenue
Cancer Center

Patient Name: _____ Birthdate: _____

ONCOLOGY SUPPLEMENTAL MEDICAL HISTORY QUESTIONAIRE

Type of Admission: [ ] Hematology/Chemotherapy [ ] Radiation Therapy Today's Date (mm/dd/yyyy): _____/ _____/ _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Supplemental Surgical History

Surgeries:

- ☐ Abdominal Aortic Aneurysm
- ☐ Angioplasty
- ☐ Cardiac Surgery
- ☐ Carotid Endarterectomy
- ☐ CABG/Coronary Artery Bypass Graft
- ☐ ICD/Implantable Cardiovert/Defibrillator
- ☐ Open Heart Surgery
- ☐ Pacemaker
- ☐ Vascular Surgery
- ☐ Appendectomy
- ☐ Bowel Surgery
- ☐ Cholecystectomy
- ☐ Gastrointestinal Surgery
- ☐ Splenectomy
- ☐ Weight Loss Surgery
- ☐ Abdominal Surgery
- ☐ Breast Surgery
- ☐ C-Section
- ☐ Tubal Ligation
- ☐ Ectopic Pregnancy
- ☐ Gynecologic Surgery
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Joint Replacement
- ☐ Kidney (Renal Surgery)
- ☐ Neurologic Surgery
- ☐ Organ Transplant
- ☐ Orthopedic Surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Transurethral Resection
- ☐ Prostatectomy

Other: _____

Vaccination History

Please check immunizations you received. Please include an approximate date for each.

- ☐ Influenza (Flu) ___/___/_____
- ☐ Diphtheria, Pertussis, Tetanus ___/ ___/ _____
- ☐ Tetanus, Diphtheria ___/ ___/ _____
- ☐ Pneumococcal (Pneumonia) ___/ ___/ _____
- ☐ Pertussis (Whooping Cough) ___/ ___/ _____
- ☐ Rubella (German Measles) ___/ ___/ _____

Other: _____

_____

Supplemental Medical History

Please check if you currently have any of the following conditions:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Congestive Heart Failure (CHF)
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack / Myocardial Infarction
- ☐ High Blood Pressure
- ☐ Mental Illness
- ☐ Pneumonia
- ☐ Renal Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer

Other: _____

_____

Review of Systems

Please check boxes to indicate if you have any of these problems frequently, or if they have worsened in the last 6 to 12 months:

GENERAL SYMPTOMS
- ☐ Fevers/Chills
- ☐ Night Sweats
- ☐ Weight Loss

EYES
- ☐ New Trouble seeing
- ☐ Double Vision
- ☐ Pain

EARS/NOSE/MOUTH/THROAT
- ☐ Pain
- ☐ Nasal Obstruction
- ☐ Bleeding From Nose

HEART & ARTERIES
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Calf Pain with Walking
- ☐ Pacemaker/Defibrillator

LUNGS
- ☐ Shortness of Breath
- ☐ Increasing Cough
- ☐ Increasing Wheezing
- ☐ Coughing up Blood

SKIN
- ☐ Rash
- ☐ Itching

STOMACH & INTESTINES
- ☐ Trouble Swallowing
- ☐ Indigestion/Heartburn
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Change in Bowel Movements
- ☐ Blood In or Black Stool

MUSKULOSKELETAL
- ☐ New Bone Pain
- ☐ Focal Weakness
- ☐ Where: _____

BLOOD/LYMPHATICS
- ☐ Easy Bruising/Bleeding
- ☐ New or Swollen Nodes

GENITOURINARY
- ☐ Urine Leaking
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urine Frequency
- ☐ Trouble Voiding

NEUROLOGICAL
- ☐ New Headaches
- ☐ Dizzy Spells
- ☐ Numbness/Weakness

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Thoughts of Hurting Self

MALE
- ☐ Trouble Having Erection

FEMALE
- ☐ New Blood From Vagina
- ☐ Heavy Blood From Vagina

Last Mammogram: (mm/dd/yyyy)
____/____/_____

Last Pelvic Exam: (mm/dd/yyyy)
____/____/_____

Date of Menopause or Last Menstrual Period: (mm/dd/yyyy)
____/____/_____

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ONCOLOGY SUPPLEMENTAL MEDICAL HISTORY QUESTIONAIRE (*continued...*)

Medical Consultation Information

Reason for consultation:

_____

_____

Referring Physician:

_____

History of present illness:

_____

_____

_____

First date of this illness: ____/ ____/ _____

Physician who diagnosed this illness: _____

History of Hospitalization

Please list past hospitalizations and dates:

Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____

History of Injury & Occupational Exposure

Please list major injuries and dates:

Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____

Please list any occupational exposure and dates:

Date: ____/____/_____ Description: _____
Date: ____/____/_____ Description: _____

History of Cancer

Please list any chemotherapy and include the area treated:

_____

_____

Please list any radiation therapy and include the area treated:

_____

_____

Home address at time of diagnosis:

_____

_____

Other Concerns

Please list any other concerns that you would like to discuss with the doctor:

_____

_____

_____

_____

Assistant Signature: X_____ Physician Signature: X_____