Los Angeles Cancer Network
New Patient Health Questionnaire

NAME: _____

DATE OF BIRTH: _____

DATE COMPLETED: _____

Dear Patient,

In order to offer optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you spending ten to twenty minutes completing this comprehensive health questionnaire.

Review of Systems

For the Review of Systems section, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example ■ Yes ☐ No

General

Chills	☐ Yes ☐ No	Change in Appetite	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Weight Gain	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
Sleep Disturbance	☐ Yes ☐ No	Lightheadedness	☐ Yes ☐ No
Frequent or Persistent Headaches	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No

Skin

Acne	☐ Yes ☐ No	Dry Skin	☐ Yes ☐ No
Rash	☐ Yes ☐ No	Discoloration	☐ Yes ☐ No
New Skin Moles	☐ Yes ☐ No	Eczema	☐ Yes ☐ No

Behavioral

Anxiety	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Mental or Physical Abuse	☐ Yes ☐ No	Suicidal Thoughts	☐ Yes ☐ No
Auditory/Visual Hallucinations	☐ Yes ☐ No	Disorder	☐ Yes ☐ No

Neurologic

Numbness or Tingling in Hands/Feet	☐ Yes ☐ No	Memory Loss	☐ Yes ☐ No
Difficulty Balancing / Frequent Falls	☐ Yes ☐ No	Fainting	☐ Yes ☐ No
Tremor	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Pain	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No

Patient Name: _____

Endocrine

Heat Intolerance	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No
Cold Intolerance	☐ Yes ☐ No	Frequent Urination	☐ Yes ☐ No

Eyes

Flashes of Light in Visual Field	☐ Yes ☐ No	Decreased Vision	☐ Yes ☐ No
Floaters in Visual Field	☐ Yes ☐ No	Blurred Vision	☐ Yes ☐ No
Elevated Pressure	☐ Yes ☐ No	Dry Eyes	☐ Yes ☐ No

Ear / Nose / Throat

Decreased Hearing	☐ Yes ☐ No	Dry Mouth	☐ Yes ☐ No
Ringing in the Ears	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No
Ear Pain	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No
Sinus Pain or Infection	☐ Yes ☐ No	Swollen Glands	☐ Yes ☐ No

Allergy

Itching	☐ Yes ☐ No	Sneezing	☐ Yes ☐ No
Hives	☐ Yes ☐ No	Watery Eyes	☐ Yes ☐ No

Respiratory

Wheezing	☐ Yes ☐ No	Dry Cough	☐ Yes ☐ No
Shortness of Breath at Rest	☐ Yes ☐ No	Productive Cough	☐ Yes ☐ No
Shortness of Breath with Exertion	☐ Yes ☐ No	Bloody Cough	☐ Yes ☐ No

Cardiovascular

Shortness of Breath When Lying Flat	☐ Yes ☐ No	Chest Pain at Rest	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Chest Pain with Exertion	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Ankle Swelling	☐ Yes ☐ No

Peripheral Vascular

Decreased Sensation in Hands/Feet	☐ Yes ☐ No	Foot or Leg Ulcers	☐ Yes ☐ No
Cold hands or feet	☐ Yes ☐ No	Leg Pain when Walking	☐ Yes ☐ No

Breast

Breast Pain	☐ Yes ☐ No	Skin Redness	☐ Yes ☐ No
Nipple Discharge	☐ Yes ☐ No	Enlarged Lymph Nodes	☐ Yes ☐ No
Nipple Retraction/Inversion	☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No

Patient Name: _____

Gynecologic

Hot Flashes	☐ Yes ☐ No	Irregular Periods	☐ Yes ☐ No
Vaginal Discharge/Itching	☐ Yes ☐ No	Missed Periods	☐ Yes ☐ No
Vaginal Bleeding Between Period	☐ Yes ☐ No	Heavy Periods	☐ Yes ☐ No
Painful Intercourse	☐ Yes ☐ No	Painful Periods	☐ Yes ☐ No

Gastrointestinal

Heartburn/Indigestion	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Nausea	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Abdominal Pain	☐ Yes ☐ No	Blood in Stool	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Rectal Bleeding	☐ Yes ☐ No

Urinary

Urinary Incontinence	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No
Change in Force of Stream	☐ Yes ☐ No	Painful Urination	☐ Yes ☐ No

Hematology (Blood)

Easy Bruising	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No

Musculoskeletal

Painful Joints	☐ Yes ☐ No	Leg Cramps	☐ Yes ☐ No
Swollen Joints	☐ Yes ☐ No	Muscle Aches	☐ Yes ☐ No

OB/Gyn History

Age at First Menstrual Period	_____	Total Pregnancies	_____
Date of Last Menstrual Period	_____	Number of Live Births	_____
Birth Control Pills Used	☐ Yes ☐ No	Number of Miscarriages	_____
	_____	Number of Abortions	_____
		Number of C-Sections	_____
Hormone Replacement Therapy Used	☐ Yes ☐ No	Number of Ectopic Pregnancies	_____
If yes, number of years	_____	Age When First Child was Born	_____

Patient Name: _____

Medical History

For Medical History, please indicate if you have ever been diagnosed with or treated for any of the following conditions.

	Yes		Yes
Asthma	☐	Neurologic Disorder	☐
Bronchitis	☐	Anxiety Disorder / Panic Attacks	☐
Hyperthyroidism	☐	Carpal Tunnel	☐
Hypothyroidism	☐	Sleep Apnea	☐
Tuberculosis	☐	Kidney Stones	☐
Thrombosis / Blood Clots	☐	Kidney Disease	☐
Varicose Veins	☐	Autoimmune Disorder	☐
Diabetes, Type I (Insulin Dependent)	☐	HIV / AIDS	☐
Diabetes, Type II (Non-insulin Dependent)	☐	Lupus	☐
Heart Murmur	☐	Hepatitis B	☐
Hypercholesterolemia / High Cholesterol	☐	Hepatitis C	☐
Hypertension / High Blood Pressure	☐	Mitral Valve Prolapse	☐
Coronary Artery Disease / Angina	☐	Osteoporosis	☐
Abnormal Pap Smear	☐	Gout	☐
Abnormal Uterine Bleeding	☐	Multiple Sclerosis	☐
Arthritis	☐	Alcohol Abuse	☐
Rheumatoid Arthritis Schizophrenia	☐	Drug Abuse	☐
Depression / Mania / Bipolar Disorder	☐		

Other Diagnosed Conditions:

Preventive Health (indicate date of last screening)

	Date (Mo/Yr)		Date (Mo/Yr)
Pap Smear	_____	Bone Density	_____
Mammogram	_____	Cholesterol Measurement	_____
Colonoscopy	_____		

Patient Name: _____

Social History

Alcohol Consumption:

Frequency..... ☐ Less than 1 drink per week ☐ 2-3 drinks per week
☐ 1 drink per day ☐ 2 or 3 per day ☐ More than 3 per day

Tobacco Use:

Do you Smoke?..... ☐ Yes ☐ No Cigarettes per day? _____

Hospitalizations and Surgeries

Month/Year	*Reason*

Allergies

Substance	*Reaction*

Current Medications (including over-the-counter meds, vitamins, nutritional supplements)

Name	*Strength*	*Qty*	*Frequency*	*Start Date*	*Stop Date*

Patient Name: _____

Family Medical History

Family History
Age at which member was diagnosed

Family Members		Status (A / D / U) Alive, Deceased, Unkown	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Prostate Cancer	Stomach Cancer	Pancreatic Cancer	Melanoma	Heart Disease	High Blood Pressure	Diabetes	Other
Example		*A*	*62*									*51*		*Lymphoma (68)*
Paternal Family	Father			n/a	n/a									
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Maternal Family	Mother						n/a							
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Personal	Self													
	Sister						n/a							
	Brother			n/a	n/a									

Patient Name: _____

Durable Power of Attorney

Do you have a durable power of attorney?..... ☐ Yes ☐ No

If yes, please provide us with a copy.

Do you have a next of kin or person who will make decisions for you if needed?..... ☐ Yes ☐ No

If yes, please give name & phone number, and explain relationship: _____

_____

_____

Ethnic Extraction

Please check **one or more** categories that describe you:

☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander

☐ American Indian/Alaska Native ☐ Asian ☐ Other *(specify)* _____

_____

Are you Hispanic or Latino?..... ☐ Yes ☐ No

Preferred Language: _____

Religion: _____