PATIENT HISTORY QUESTIONNAIRE

Patient Name: ________________ Date of Birth: __________ Age: __________
Stated Height: __________ Stated Weight: __________ Primary Language: ________________
Interpreter Needed? ☐ No ☐ Yes If yes, for which language? ________________
Contact Person: __________ Tel #: Home ( ) __________ Work ( ) __________ Cell ( ) __________
Procedure: ________________ Date of Procedure: ________________
Physician performing procedure: ________________ Primary Care Physician: ________________
Internist: __________ Last seen: __________ Oncologist: __________ Last seen: __________

ALLERGIES and ALLERGY REACTIONS:

LIST PREVIOUS SURGERIES: Year Complications Type of Anesthesia

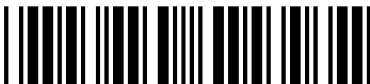
MEDICATIONS: List medication name only; no dosage information is needed.
(Includes over-the-counter, herbal remedies, inhalers, eye drops, or recreational drugs)

1	5	9
2	6	10
3	7	11
4	8	12

Please check appropriate box in each section below:

CARDIOVASCULAR	Yes	No		Yes	No
Hypertension/High Blood Pressure	☐	☐	Angina/Chest Pain	☐	☐
Heart Attack – Date:__________	☐	☐	Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs	☐	☐
Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐
Cardiomyopathy	☐	☐	Poor Circulation in lower extremities	☐	☐
Congestive Heart Failure	☐	☐	Family history of heart disease	☐	☐
Arrhythmias i.e. A-Fib	☐	☐	(age of onset)		
Pacemaker/AICD	☐	☐	Father ____ Mother ____ Siblings ____		
Rheumatic Fever	☐	☐			
Heart Valve problems	☐	☐			
Heart murmur	☐	☐			
Carotid Artery Disease	☐	☐			

PULMONARY	Yes	No		Yes	No
Asthma	☐	☐	Blood clots in lungs or legs	☐	☐
COPD/Bronchitis/Emphysema (circle)	☐	☐	Sleep Apnea	☐	☐
Pneumonia	☐	☐	Chronic Cough	☐	☐
Tuberculosis	☐	☐	Oxygen Use @ ______ L/min	☐	☐
Asbestos Exposure	☐	☐			



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Addressograph

EYES, EARS, NOSE, THROAT	Yes	No
Abnormal vision	☐	☐
☐ Right ☐ Left ☐ Both sides		
Hearing loss	☐	☐
☐ Right ☐ Left ☐ Both sides		
Hoarseness	☐	☐
New lumps	☐	☐
Location: ____________________		

GASTROINTESTINAL	Yes	No
Hiatal Hernia	☐	☐
Ulcers/GERD/Gastric Reflux (circle)	☐	☐
Gallstones	☐	☐
Liver Disease	☐	☐
Hepatitis A, B or C	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐

GENITOURINARY	Yes	No
Urinary Tract Infections	☐	☐
Kidney Stones	☐	☐
Prostate Disease	☐	☐
Penile Prosthesis	☐	☐
Dialysis	☐	☐
Urinary Incontinence	☐	☐
Colostomy/Ileostomy/Foley catheter	☐	☐

HEMATOLOGIC	Yes	No
Anemia	☐	☐
Bleeding Disorders	☐	☐
Blood Diseases i.e. Leukemia	☐	☐
Blood Transfusions	☐	☐
Easy Bruising	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Oral/Insulin Dependent	☐	☐
Hypo/Hyperthyroidism	☐	☐
Hypoglycemia	☐	☐
Pituitary	☐	☐

NEUROLOGIC	Yes	No
Stroke/TIA's	☐	☐
Seizures; Describe: ____________	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Paralysis	☐	☐
Muscle Weakness	☐	☐
Headache	☐	☐
Fainting/Dizziness	☐	☐
Numbness/Tingling	☐	☐
Depression	☐	☐
Memory problems	☐	☐

MUSCULOSKELETAL	Yes	No
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Chronic Pain Treatment	☐	☐
Back/Neck Pain	☐	☐
Artificial Joints; Location: ____________	☐	☐
Fall risk	☐	☐
Balance difficulty	☐	☐
Assistive device: ☐ Wheelchair ☐ Cane ☐ Walker		
Prosthesis: ☐ Left ☐ Right		
Describe: ____________________		

GENERAL HEALTHCARE	Yes	No
Rashes; Location: ____________	☐	☐
Healing incisions; Location: ____________	☐	☐
Sores; Location: ____________	☐	☐
Extremity Swelling; Location: ____________	☐	☐
Frequent infections	☐	☐
Porta cath; Location: ____________	☐	☐
PICC line; Location: ____________	☐	☐
Last flush: ____________		

Social History:

	Yes	No
Do you drink alcohol? Amount: ________	☐	☐
Do you smoke?	☐	☐
Did you ever smoke? Years: ________	☐	☐
Have you smoked in the past 12 months?	☐	☐

	Yes	No
Do you use recreational drugs/alcohol?	☐	☐
Type: ____________________		
Have you had:		
Immune Deficiency/HIV	☐	☐
Measles/Mumps/Rubella (circle)	☐	☐
Chicken Pox	☐	☐
MMR Vaccine	☐	☐
Flu Vaccine – Date: ____________	☐	☐
Pneumonia Vaccine – Year: ____________	☐	☐
TB Skin Test	☐	☐
☐ Positive ☐ Negative ☐ Unknown		
If female: possibility of pregnancy?	☐	☐
Last menstrual period: ____________		
Other: ____________________	☐	☐

Addressograph

SURGICAL INFORMATION	Yes	No
Do you have any specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living alone	☐	☐
Transportation	☐	☐
Insurance	☐	☐
Do you exercise? Type: ______________	☐	☐
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures or loose teeth?	☐	☐

Do you need information on:	Yes	No
Current surgery	☐	☐
Medications	☐	☐
Activities	☐	☐
Home Care	☐	☐
History of Malignant Hyperthermia (MH)	☐	☐
Family history of anesthesia problems or MH (circle)	☐	☐

CANCER HISTORY	Yes	No
History of Cancer	☐	☐
If Yes: Primary site: ______________		
Cancer site: ______________		
Oncologist: ______________		
Last Pet or CT scan date: ______________		
Imaging Center: ______________		
Prior radiation therapy	☐	☐
If Yes: Site treated: ______________		
Facility: ______________		
Prior chemotherapy	☐	☐
If Yes: Last treatment: ______________		
Facility: ______________		
Are you taking blood thinners?	☐	☐

PAIN HISTORY	Yes	No
Current pain	☐	☐
If Yes: ☐ New onset ☐ Chronic		
If Chronic, do you receive chronic pain treatment? If Yes, by whom: ______________	☐	☐
Location of pain: ______________		
Cause of pain: ______________		
Describe pain: ______________		
Intensity level: ______________(0=no pain, 10= most severe)		
Does pain radiate?	☐	☐
If Yes: Where? ______________		
Time of onset: ______________		
What relieves the pain? ______________		
Goal for pain relief: ______________		

DIETARY/FUNCTIONAL STATUS

Recent weight loss or gain?	☐ Yes	☐ No	Amount: ______________
Special or restricted diet?	☐ Yes	☐ No	Describe: ______________
Any problems with swallowing?	☐ Yes	☐ No	Describe: ______________
Feeding tube?	☐ Yes	☐ No	# of ________ cans of ______________ /per day

How do you manage these self care activities?

	Independent	Needs assistance
Feeding	☐	☐
Walking	☐	☐
Bathing	☐	☐
Dressing	☐	☐
Toileting	☐	☐
Meal preparation	☐	☐

Comments:
____
____
____
____
____
____

______________ [Patient/Parent/Conservator/Guardian]
______________ [If completed by other than patient, indicate relationship]
______________ [Date]

THIS SECTION FOR HOAG FACILITY PERSONNEL USE ONLY

______________ [Reviewed by Assessment Nurse] ______ [Date] ______ [Time] ______________ [Reviewed by Procedure Nurse] ______ [Date] ______ [Time]

PATIENT HISTORY QUESTIONNAIRE
Gamma Knife

Addressograph