SOUTHERN CANCER CENTER
Surgical Services
Eric Roberts, DO, FACS
General Surgeon

Patient Name: _____
Patient DOB: _____

Health Questionnaire

PHYSICIAN AND PHARMACY INFORMATION

Physician who **referred** you to this visit_____ **or** □ Self referred

Primary Care Physician:

_____ _____
Name Specialty
_____ (_____)_____
City State Telephone

Specialty physician (Surgeon, Ob/Gyn, Oncologist, Cardiologist, other):

_____ _____
Name Specialty
_____ _____
Name Specialty

Pharmacy: For most of our pharmacy needs, we use:

_____ _____
Name of Pharmacy Address
_(_____)_____ _____
Telephone City State Zip

Are you currently staying in a Skilled Nursing Facility, Convalescent Home or enrolled in Home Health or Hospice? □ Yes □ No (*NOTE: if NO, Patient or Caregiver must immediately notify staff if patient is admitted to a hospital, SNF, Convalescent Home or Hospice).*

_____
Name of Facility Phone

_____
Address City State Zip

MEDICAL HISTORY

Allergies and Sensitivities - *If you have a history of penicillin allergy, please note date of onset, reaction, and whether you have been able to take Keflex, Amoxicillin, Augmentin afterwards.*

Allergic to:	Reaction:

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Medications - Please list all medications you are currently taking, including those you buy without a doctor's prescription.

Name	Dose	Directions/Number per day

Do you currently take oral iron supplements? Yes or No

Do you have any of the following illnesses? If so, please mark with an X:

- □ High blood pressure
- □ Diabetes
- □ Heart attack
- □ Congestive heart failure
- □ Heart murmur
- □ Stroke
- □ Liver disease
- □ Hepatitis
- □ Kidney disease
- □ Thyroid disease
- □ Autoimmune/connective tissue disease (lupus, scleroderma etc.)
- □ HIV/AIDS
- □ Asthma/COPD
- □ Tuberculosis
- □ Sleep apnea
- □ Reflux/GERD
- □ Depression
- □ Anxiety
- □ Arthritis
- □ Easy bleeding
- □ Blood clots
- □ Anemia
- □ Atrial Fibrillation
- □ Pacemaker
- □ Other_____
- □ _____
- □ _____
- □ _____
- □ _____

Have you ever been diagnosed with cancer? If yes, did you receive chemotherapy? □ Yes □ No
Describe the situation: _____

Have you ever received radiation? □ Yes □ No
Describe the situation: _____

Do you have any metal in the body? □ Yes □ No If yes, explain: _____

Please list: 1) Prior surgeries/procedures/hospitalizations
2) Recent scans/tests

Date	Description	Physician/Medical Facility

Patient Name: _____
Patient DOB: _____

Health Maintenance: Please list the date of last exam and, if abnormal, any findings if known.

- Last Mammogram: ____/____/____ Location: _____
- Last PAP Smear: ____/____/____ Location: _____
- Last Colonoscopy: ____/____/____ Location: _____
- Last Bone Density (DEXA) Scan: ____/____/____ Location: _____
- Last Echocardiogram: ____/____/____ Location: _____
- Shingles vaccine: ____/____/____
- Influenza vaccine: ____/____/____
- Pneumovax vaccine: ____/____/____
- COVID-19 vaccine: ____/____/____ **Circle One:** Janssen Pfizer Moderna

FAMILY HISTORY

Do you have a family history of:	Yes (Y) or No (N)	Which Relative?
Diabetes	□ Y □ N	
High Blood Pressure	□ Y □ N	
Heart Attack	□ Y □ N	
Stroke	□ Y □ N	
Kidney Disease	□ Y □ N	
Thyroid Disease	□ Y □ N	
Autoimmune Disease	□ Y □ N	
Easy Bleeding	□ Y □ N	
Blood Clots	□ Y □ N	
Breast Cancer	□ Y □ N	

Familial Cancer History

Do you have a family history of:	Yes (Y) or No (N)	Which Relative?	Maternal (M) or Paternal (P) side?	Age at diagnosis?
Ovarian Cancer	□ Y □ N		□ M □ P	
Uterine Cancer	□ Y □ N		□ M □ P	
Colon Cancer	□ Y □ N		□ M □ P	
Prostate Cancer	□ Y □ N		□ M □ P	
Pancreatic Cancer	□ Y □ N		□ M □ P	
Melanoma	□ Y □ N		□ M □ P	
Lung Cancer	□ Y □ N		□ M □ P	
Lymphoma	□ Y □ N		□ M □ P	
Leukemia	□ Y □ N		□ M □ P	
Other	□ Y □ N		□ M □ P	

Patient Name: _____
Patient DOB: _____

SOCIAL HISTORY

Currently live: □ Alone □ With family □ With significant other □ With friends
Do you have transportation to and from appointments? □ Yes □ No
Marital status: □ Married □ Separated □Divorced □ Widowed □ Never married
Occupational Status: □ Employed □ Retired □ Disabled
Occupation:_____
Do you have children? □ Yes □ No Ages: _____
Do you currently smoke or chew tobacco? □ Yes □ No Cigarettes per day:_____ Packs per week: _____
Duration of habit (yrs.): _____ If you have a history of smoking, when did you quit? _____
How would you describe your use of alcohol?_____
Amount per week of: Beer_____ Wine_____ Liquor_____
Do you now, or have you in the past, used drugs? □ Yes □ No Type: _____

REVIEW OF SYSTEMS

For each category, please circle any of the issues that currently apply to you.

Category	Issues	No Problems
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	□
Skin	Itching, rash, mole change	□
Eyes	Vision change, cataracts, glaucoma	□
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	□
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	□
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	□
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	□
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	□
Breasts	Discharge, mass, pain, tenderness	□
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	□
Nervous System	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling	□
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	□
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	□
Lymph nodes	Enlargement, tenderness	□
Hematologic	Bruising, bleeding, recurrent infections	□

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Gynecologic History (Female Only)

- At what age did you start menstruating? _____years old
- Last menstrual period: ____/____/____
- Are you pregnant? □ Yes □ No
- *Total* number of pregnancies_____ Miscarriages/terminations_____ Number living children_____
- Age at first pregnancy _____years old
- Do you wish to maintain future fertility? □ Yes □ No □ Not applicable
- Are you sexually active? □ Yes □ No
- Onset of menopause: _____year/age
- Last Pap smear: ____/____/____
- Any abnormal Pap smears? □ Yes □ No Description: _____
- Any history of pelvic infections (Gonorrhea, Chlamydia, herpes)? Description: _____
- Did you ever breast feed? □ Yes □ No If yes, for how long?_____
- Have you ever taken oral contraceptive pills? □ Yes □ No If yes, for how long?_____
- Have you ever taken hormone replacement therapy? □ Yes □ No If yes, for how long?_____
- Are you currently on a bisphosphonate (Aredia, Fosamax, Boniva, Reclast, Prolia, Actonel, Olpadronate, Nerixia)?