UCSF Helen Diller Family Comprehensive Cancer Center

Patient Name _____

Date of Birth _____

Thank you for choosing the UCSF Helen Diller Family Comprehensive Cancer Center. We are excited to meet you. Please answer the following questions about your health. We will put these answers in your confidential UCSF medical record. To ensure accuracy of your records, *please put your name and date of birth on the top of every page.*

Contact Information

Patient Name _____

Home Address _____

City _____ State _____ ZIP _____

Primary Phone Number _____ ◯Home ◯Fax ◯Work ◯Cell

Second Phone Number _____ ◯Home ◯Fax ◯Work ◯Cell

Other Phone Number _____ ◯Home ◯Fax ◯Work ◯Cell

Email _____

Important
Please complete this New Patient Health Questionnaire and return it to us at least 3 days before your first appointment. It will help us prepare for your visit. If you are unable to read or write in English, please ask a family member or friend to assist you. Thank you.

IMPORTANTE
Por favor, llene este formulario de salud para pacientes nuevos, y regréselo a nuestra oficina por lo menos 3 días antes de su primera cita. Al disponer de esta información antes de su cita, estaremos mejor preparados para su consulta. Si no sabe leer o escribir inglés, pida la ayuda de un familiar o amigo. Gracias.

Очень Важно
Пожалуйста, заполните этот и возвратите его нам по крайней мере за три дня до до вашего первого посещения! Наличие этой информации поможет нам приготовиться к вашему визиту. Если Вы не можете читать или писать на английском языке, пожалуйста, попросите, чтобы Вам помог член семьи или друг. Спасибо!

親愛的病患:

注意項目: **健康問卷**

請將健康問卷盡早填寫。此健康問卷將幫助我們準備您您將來的醫生預約;我們的目標是在ン您會見醫生三天之前收到這份健康問卷, 煩請盡快遞交。如果您有任何讀 寫英語的困難, 敬請您的家人或朋友協助填寫。

Language Preference

Would you like an interpreter to translate during your appointments? ◯Yes ◯No

If Yes, what is your preferred language? _____

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Family/Friend Contacts

Would you like us to discuss your health care with a family member and/or friend? ◯ Yes ◯ No

If Yes, please provide their information below.

Contact's Name _____

Contact's Relationship to You _____

Contact's Phone _____ ◯ Home ◯ Work ◯ Cell

Contact's Name _____

Contact's Relationship to You _____

Contact's Phone _____ ◯ Home ◯ Work ◯ Cell

--this section is intentionally blank--

Other Physicians

We would like to send your other physicians updates on your treatment here at the Cancer Center. Please provide their contact information below so that we can ensure strong communication between all the physicians on your care team.

Referring Physician

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Primary Care Physician

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

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Other Physicians (Continued)

Surgeon

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Medical Oncologist

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Radiation Oncologist

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Cardiologist

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Other Physician

Physician Name _____

Physician Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

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Allergies

Have you ever had an allergic reaction to any of these? Please check all that apply.

Eggs
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

Latex
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

Iodine including Shellfish
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

Bee Stings
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

Intravenous Contrast (used in CT scans)
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

Have you ever had an allergic reaction to a medication? Please check all that apply.

Medication Name

_____
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

_____
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

_____
☐ anaphylaxis/shock ☐ short-of-breath ☐ nausea/vomiting
☐ itching ☐ rash other _____

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Medical History

Arrhythmias or Coronary Artery Disease (CAD)	◯ Yes	◯ No
Anemia (low red blood cell count)	◯ Yes	◯ No
Angina (heart pain from poor blood flow)	◯ Yes	◯ No
Anxiety or Panic Attacks	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No
Asbestos Exposure	◯ Yes	◯ No
Asthma/Bronchitis	◯ Yes	◯ No
Atrial Fibrillation (A fib or heart flutter)	◯ Yes	◯ No
Autoimmune Disease	◯ Yes	◯ No
Bleeding Disorders (hemophilia)	◯ Yes	◯ No
Blood Disorder	◯ Yes	◯ No
Blood Transfusion in the past	◯ Yes	◯ No
Cancer (see cancer section, too)	◯ Yes	◯ No
Chest Pain	◯ Yes	◯ No
Chronic Bronchitis	◯ Yes	◯ No
Chronic Obstructive Pulmonary Disease (COPD)	◯ Yes	◯ No
Cirrhosis (liver failure)	◯ Yes	◯ No
Hiatal Hernia	◯ Yes	◯ No
HIV / AIDS	◯ Yes	◯ No
Hypertension / High Blood Pressure	◯ Yes	◯ No
Immune Disorders	◯ Yes	◯ No
Intestinal Disease / Problems	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No
Melanoma	◯ Yes	◯ No
Migraine Headaches	◯ Yes	◯ No
Morbid Obesity BMI >=38	◯ Yes	◯ No
Myocardial Infarction (MI / heart attack)	◯ Yes	◯ No
Nerve / Muscle Disease	◯ Yes	◯ No
Osteoporosis (loss of bone strength)	◯ Yes	◯ No
Pancreatitis (chronic)	◯ Yes	◯ No
Palpitations / Fast or Irregular Heart Beats	◯ Yes	◯ No
Peripheral Vascular Disease	◯ Yes	◯ No
Psychiatric Treatment / Mental Illness	◯ Yes	◯ No

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Medical History Continued

Clotting Disorder	◯ Yes	◯ No
Congestive Heart Failure (CHF)	◯ Yes	◯ No
Deep Vein Thrombosis (DVT)	◯ Yes	◯ No
Depression	◯ Yes	◯ No
Diabetes Mellitus-IDDM (taking insulin)	◯ Yes	◯ No
Diabetes Mellitus-NDDM (not taking insulin)	◯ Yes	◯ No
Easy Bruising	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Gastroesophageal Reflux/GERD/Heartburn/ Stomach Reflux	◯ Yes	◯ No
GI Bleed	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Valve Problems	◯ Yes	◯ No
Hepatitis Chronic	◯ Yes	◯ No

Pulmonary Embolism (blood clot in lungs)	◯ Yes	◯ No
Renal Disease/Failure/ Insufficiency/CRI	◯ Yes	◯ No
Seizures/Epilepsy	◯ Yes	◯ No
Sexually Transmitted Infection (STI)	◯ Yes	◯ No
Sinus Disorder	◯ Yes	◯ No
Skin Disease	◯ Yes	◯ No
Stomach Ulcers	◯ Yes	◯ No
Stroke/Mini-Stroke/ Transient Ischemic Attack/TIA	◯ Yes	◯ No
Substance Abuse (see later section)	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Tuberculosis (TB)	◯ Yes	◯ No
Ulcers (open sores that don't heal)	◯ Yes	◯ No

Have you ever been diagnosed with any other medical conditions such as high cholesterol or high blood pressure? If yes, please list all of them here.

_____

_____

Have you ever been hospitalized? ◯ Yes ◯ No

Date _____ Reason _____

Date _____ Reason _____

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Past Surgeries

Appendix Surgery	◯ Yes	◯ No	Date/Comments _____
Brain Surgery	◯ Yes	◯ No	Date/Comments _____
Breast Surgery	◯ Yes	◯ No	Date/Comments _____
Caesarean Section	◯ Yes	◯ No	Date/Comments _____
Colon Surgery	◯ Yes	◯ No	Date/Comments _____
Coronary Artery Bypass Surgery (CABG)	◯ Yes	◯ No	Date/Comments _____
Gallbladder Surgery	◯ Yes	◯ No	Date/Comments _____
Heart Valve Replacement (pacemaker)	◯ Yes	◯ No	Date/Comments _____
Hernia Repair	◯ Yes	◯ No	Date/Hernia Location _____
Hysterectomy (Uterus Removal)	◯ Yes	◯ No	Date/Comments _____
Joint Replacement	◯ Yes	◯ No	Date/Joint _____
Liver Surgery	◯ Yes	◯ No	Date/Comments _____
Ovary Surgery	◯ Yes	◯ No	Date/Comments _____
Pancreas Surgery	◯ Yes	◯ No	Date/Comments _____
Prostate Surgery	◯ Yes	◯ No	Date/Comments _____
Spine Surgery	◯ Yes	◯ No	Date/Comments _____
Tonsillectomy	◯ Yes	◯ No	Date/Comments _____
Tubal Ligation	◯ Yes	◯ No	Date/Comments _____
Vasectomy	◯ Yes	◯ No	Date/Comments _____
Other _____	◯ Yes	◯ No	Date/Comments _____

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Prescription Medications, Over-The-Counter Medications, and Supplements

Please ensure that everything you list here is also accounted for in the medical history section.

Name of Medication or Supplement	Form (tablet, chewable tablet, elixir, etc)	Dosage Strength per Tablet or Liquid Concentration	Amount of Medication per Dose	Frequency

Your Pharmacy

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ ZIP _____

Pharmacy Phone _____

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Cancer History

Have you ever been diagnosed with cancer? ◯ Yes ◯ No

Cancer Type _____ Date of Diagnosis _____

Treatment Received _____

Cancer Type _____ Date of Diagnosis _____

Treatment Received _____

Have you ever been been treated with chemotherapy? ◯ Yes ◯ No

Drug Regimen _____

Start Date _____ Date of Last Dose _____ Number of Cycles _____

Drug Regimen _____

Start Date _____ Date of Last Dose _____ Number of Cycles _____

Have you ever been been treated with radiation? ◯ Yes ◯ No

Area of Body Radiated _____

Start Date _____ Completion Date _____ Dose _____

--this section is intentionally blank--

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Family History

Were you adopted? ◯ Yes ◯ No

Relationship to Patient	Type of Cancer	Other Medical Conditions	Age at Diagnosis	Current Age	If Deceased, Age at Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					
Daughter					
Son					
Maternal Aunt					
Maternal Uncle					
Paternal Aunt					
Paternal Uncle					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Other					
Other					

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Lifestyle

Do you drink alcohol? ◯ Yes ◯ No

If Yes, what is your average number of: Glasses of Wine per Week _____

Cans of Beer per Week _____

Shots of Liquor per Week _____

In regards to smoking, please check one. ◯ Current Smoker ◯ Former Smoker ◯ Never Smoked ◯ Passive Smoker (2nd Hand)

How many years have you/did you smoke? _____

How many packs of cigarettes per day do you/did you smoke? _____

If you quit, when did you quit? (approximate month/day/year) _____

Do you use smokeless tobacco? ◯ Current User ◯ Former User ◯ Never Used

Do you use any of the following drugs for recreation now?

Amphetamines	◯ Yes	◯ No	Marijuana	◯ Yes	◯ No
Amyl Nitrate	◯ Yes	◯ No	MDMA Ecstasy	◯ Yes	◯ No
Anabolic Steroids	◯ Yes	◯ No	Methamphetamine	◯ Yes	◯ No
Barbiturates	◯ Yes	◯ No	Methaqualone	◯ Yes	◯ No
Benzodiazepines	◯ Yes	◯ No	Methylphenidate	◯ Yes	◯ No
"Crack" Cocaine	◯ Yes	◯ No	Morphine	◯ Yes	◯ No
Cocaine	◯ Yes	◯ No	Nitrous Oxide	◯ Yes	◯ No
Codeine	◯ Yes	◯ No	Opium	◯ Yes	◯ No
Fentanyl	◯ Yes	◯ No	Oxycontin	◯ Yes	◯ No
GHB	◯ Yes	◯ No	PCP	◯ Yes	◯ No
Heroin	◯ Yes	◯ No	Psilocybin	◯ Yes	◯ No
Hydrocodone	◯ Yes	◯ No	Solvent Inhalants	◯ Yes	◯ No
Hydromorphone	◯ Yes	◯ No	Other _____	◯ Yes	◯ No
Ketamine	◯ Yes	◯ No	Other _____	◯ Yes	◯ No
LSD	◯ Yes	◯ No	Other _____	◯ Yes	◯ No

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Female Patients

Have you ever had an abnormal mammogram? ◯ Yes ◯ No ◯ Never Had a Mammogram

If Yes, when? _____ What were the results? _____

How were you treated? _____

_____

Have you ever had an abnormal PAP smear? ◯ Yes ◯ No ◯ Never Had a PAP smear

If Yes, when? _____ What were the results? _____

How were you treated? _____

_____

Have you ever had a sexually transmitted disease (STD) or genital or anal warts? ◯ Yes ◯ No

If Yes, when? _____ Which one? _____

How were you treated? _____

_____

Are you pregnant? ◯ Yes ◯ No ◯ Not Sure

Have you ever been pregnant? ◯ Yes ◯ No

Number of Live Births _____ Number of Multiple Births _____

Number of Ectopic Pregnancies _____ Number of Other Miscarriages _____

Number of Abortions _____

Do you have menstrual periods? ◯ Yes ◯ No Date Last Period Started _____

Do you use birth control? ◯ Yes ◯ No Type _____

_____

Do you have problems with any of the following? Please check all that apply.

- ☐ Urinary Frequency or Urgency
- ☐ Frequent Urination at Night
- ☐ Bladder Control or Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Tract Infections (UTI)
- ☐ Vaginal Discharge
- ☐ Vaginal Pain, Itching, or Irritation
- ☐ Vaginal Dryness
- ☐ Hot Flashes
- ☐ Change in Sex Drive
- ☐ Bleeding Between Periods or After Menopause