Houston Cancer Treatment & Immunotherapy Center, PLLC

1101 Alma St. Suite 106
Houston TX 77375
Phone: (832) 336-1853 Fax: (832) 663-0559
Dr. Diane D. Nguyen, DO
Board Certified Medical Oncologist and Hematologist

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT NAME: _____ DOB: _____

DATE: _____

CHIEF COMPLAINT: _____

HOW HAVE YOU BEEN DOING SINCE LAST VIST? ANY CHANGES?

_____

_____

_____

_____

NEW ALLERGIES| *Please list any new allergies.*

Drug Name	Reaction
_____	_____
_____	_____
_____	_____

Non-Drug Allergy	Reaction
_____	_____
_____	_____

NEW MEDICATIONS| *Please list any new medications you are taking.*

Drug Name & Dose	Frequency	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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GENERAL EVALUATION OF PAIN|

Please notate pain level on a scale of 0 (no pain) to 10 (worst pain imaginable).

Current Pain Level: _____/10

If pain is not relevant to today's visit, please notate that here: ☐ Pain not relevant.

Pain with no medications: _____/10 Pain with medications: _____/10

Location of pain: _____

_____

How did pain occur?: _____

_____

REVIEW OF SYMPTOMS|

General

☐ Normal
☐ Weight Gain| ____ lbs.
☐ Weight Loss| ____ lbs.
☐ Tiredness ☐ Fever
☐ Chills ☐ Night sweats
Energy Levels: ☐ Normal ☐ Improving ☐ Decreased
☐ Other: _____

_____

Skin

☐ Normal
☐ Rash ☐ Itching ☐ Erythema
☐ Skin allergy ☐ Sun burns easily
☐ Bad sun burns in the past
☐ Long term sun exposure
Tanning booth user: ☐ Past ☐ Present
☐ Other: _____

_____

HEENT

☐ Normal
☐ Dry mouth ☐ Hoarseness ☐ Difficult swallowing ☐ Head injury
☐ Blurred vision ☐ Glasses ☐ Glaucoma Artificial Eye: ☐ Left ☐ Right ☐ Both
Blind: ☐ Left ☐ Right ☐ Both Cataracts: ☐ Left ☐ Right ☐ Both
☐ Nasal congestion ☐ Nosebleed ☐ Deviated Septum
Sinusitus: ☐ Seasonal ☐ Acute ☐ Chronic Hearing Aids: ☐ Left ☐ Right ☐ Both
Partial Deafness: ☐ Left ☐ Right ☐ Both Deaf: ☐ Left ☐ Right ☐ Both
☐ Other: _____

_____

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CARDIOVASCULAR/RESPIRATORY

☐ Normal

☐ Abnormal blood pressure	☐ Shortness of breath	☐ Difficulty breathing
☐ Palpitations	☐ Chest Pain	☐ Heart problems
☐ Heart attack	☐ Pacemaker	☐ Stroke
☐ Coronary artery disease	☐ Coughing up blood last 3 times	
☐ Chronic cough	☐ Emphysema	☐ Asthma

☐ Other: _____

BREASTS

☐ Normal

☐ Nipple retraction	☐ Discharge	☐ Lump	☐ Pain
☐ Infection	☐ Last mammography done: _____		

☐ Other: _____

GASTROINTESTINAL

☐ Normal

☐ Last bowel movement: _____		☐ Nausea
☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Rectal pain	☐ Rectal bleeding	☐ Black stool
☐ White stool	☐ Pain in abdomen	☐ Hepatitis
☐ Intestinal polyps	☐ Gastrointestinal parasite	☐ Heartburn
☐ GERD	☐ Incontinence of stool	☐ Screening Colonoscopy: _____

☐ Other: _____

GENITOURINARY

☐ Normal

☐ Pelvic pain	☐ Blood in the urine	☐ Burning when urinating
☐ Obstruction	☐ Incontinence of urine	

☐ Other: _____

GYNECOLOGIC

☐ Pre-Menopause	☐ Menopause at present	☐ Never pregnant
☐ Abnormal vaginal bleeding	☐ Endometriosis	☐ Heavy periods
☐ Prolonged periods	☐ Painful periods	☐ Irregular periods
☐ Abnormal discharge	☐ Painful intercourse	☐ Frequent yeast infections

☐ Other: _____

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MUSCULOSKELETAL/NECK

☐ Normal

☐ Neck pain	☐ Neck stiffness	☐ Neck mass
☐ Back pain	☐ Decreased range of motion	☐ Joint pain
☐ Stiff joints	☐ Swelling in the extremities	☐ Muscle atrophy
☐ Muscle cramps	☐ Muscle weakness	☐ Balance difficulties

☐ Wheelchair-bound

☐ Other: _____

_____

NEUROLOGICAL

☐ Normal

☐ Headaches	☐ Weakness	☐ Memory loss
☐ Seizures	☐ Paralysis	☐ Numbness

☐ Tingling

☐ Other: _____

_____

PSYCHIATRIC

☐ Normal

☐ Depression	☐ Anxiety	☐ Bipolar disorder
☐ Insomnia	☐ Suicidal ideation	☐ Homicidal ideation

☐ Impaired cognitive function

☐ Other: _____

_____

By signing below, I hereby certify all information is true and correct to the best of my knowledge.

_____ _____
Patient Signature Date/Time

_____ _____
Legal Representative Signature Date/Time

_____
Relationship to Patient if Legal Representative

For Office Use Only:

Ht: _____ Wt: _____ Temp: _____

B/P: _____ Pulse: _____ O2: _____