

BRAIN TUMOR CENTER

AT SAINT JOHN'S HEALTH CENTER

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Your phone numbers: Home _____ Cell: _____ E-Mail address: _____

Emergency contact person: _____ Phone number: _____

Why are you seeing Dr. Kelly? _____

What are your symptoms related to this problem?

- 1.
- 2.
- 3.
- 4.

Have you been diagnosed with other medical problems?

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Heart disease (Heart attack): _____ |
| <input type="checkbox"/> High Cholesterol/ Hyperlipidemia _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Lung disease/Asthma _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Gastro-intestinal problems _____ | <input type="checkbox"/> Kidney disease/Dialysis _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Alzheimer's/Parkinson's disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer – type? _____ | <input type="checkbox"/> Other issues: _____ |

Please list any past surgeries and the year performed:

- 1.
- 2.
- 3.

Which doctors are you currently seeing? Which doctors need a copy of today's consultation note from Dr. Kelly?

- 1.
- 2.
- 3.
- 4.

MEDICATIONS

Are you taking any medications? Y N If YES please list below:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

ALLERGIES: Do you have any allergies to medications? Y N

If YES please list below and describe your reaction to the medication:

- 1.
- 2.
- 3.
- 4.

SOCIAL HISTORY

Please fill out information below:

Married Single Children? Number: _____

Are you currently employed? _____ Current position? _____

Are you disabled? _____ How long? _____

Do you drink alcohol? _____ If yes, how often? _____ Do you smoke? _____ If yes, how often? _____

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FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

- | | |
|---|---|
| <input type="checkbox"/> Heart disease (Heart attack) _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Lung disease/Asthma _____ | <input type="checkbox"/> Kidney disease/Dialysis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Alzheimers/Parkinson's disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer – type? _____ | <input type="checkbox"/> Other issue: _____ |

REVIEW OF SYSTEMS

Please indicate any of the following symptoms you are experiencing:

General

- | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------------|--|
| | | Don't | | |
| Y | N | Know | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever, chills, sweats | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite, weight loss | |

Eyes

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye irritation/ infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma/ cataract/ eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses/ contacts |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating, blood in urine |

ENT/ Mouth

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Earache/ ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis, runny nose, allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oral ulcerations |

Respiratory

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, emphysema/bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent chest x-ray |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |

Cardiovascular

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Short of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |

Psychiatric

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety disorder |

Gastrointestinal

- | | | | | |
|--------------------------|--------------------------|--------------------------|---------------------------------------|--|
| | | Don't | | |
| Y | N | Know | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/ vomiting | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea/ constipation/ bloody stools | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/ indigestion/reflux disease | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polyps/colonoscopy | |

Genitourinary

- | | | | |
|--------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased urination |
|--------------------------|--------------------------|--------------------------|---------------------|

Musculoskeletal

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/ arthralgias/ gout |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soft tissue/ bony trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congenital deformity |

Skin

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leg ulcers/ discoloration of feet/legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruising/ bleeding tendencies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne |

Reproductive

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Normal periods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Absent periods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-menopausal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pre-menopausal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Taking birth control |

Please sign below:

Patient Signature: _____

Affix Patient Label Here