CANCER & BLOOD
SPECIALTY CLINIC
1760 Termino Ave #101
Long Beach, CA 90804
Phone: 562-735-0602 Fax: 562-490-8590

Health History Questionnaire

Past Medical History

Cardiovascular	☐ heart failure ☐ heart attacks ☐ chest pain ☐ high blood pressure ☐ blood clot
Endrocrine	☐ diabetes ☐ thyroid disease
Ear / Nose / Throat	☐ sinus infection ☐ sinus allergy ☐ seasonal allergy
Gastro Intestinal	☐ gall stones ☐ stomach ulcer ☐ pancreatitis
Gynecologic	☐ abnormal pap smear ☐ uterine fibroids ☐ pelvic infections ☐ prior pregnancy
Blood Disorders	☐ anemia ☐ leukemia ☐ tendency to bleed or bruise easily ☐ blood clots ☐ prior blood transfusion
Infectious Disease	☐ HIV ☐ viral hepititus B or C ☐ tuberculosis
Kidney	☐ chronic kidney disease ☐ kidney stones ☐ kidney infection
Neurologic	☐ stroke ☐ seizure disorder/epilepsy ☐ migraine headaches
Eyes	☐ cataract ☐ glaucoma
Psychiatric	☐ depression ☐ anxiety ☐ psychosis ☐ bipolar disorders ☐ thought of suicides
Pulmonary	☐ asthma ☐ chronic bronchitis ☐ pneumonia ☐ COPD/emphysema ☐ pulmonary embolism
Other	

Past Surgical History

List any surgeries that you have had:

Surgery	Reason	Date

List any other hospitalization that you have had:

Hospitalization	Reason	Date

Gynecological History

Age at onset of menstruation: _____

Number of births: _____

Last monthly period: _____

Number of miscarriages: _____

Age of menopause: _____

Age of first childbirth: _____

Number of pregnancies: _____

Birth control or hormone use: _____

Medications

List all medicines that you are currently taking (include prescribed drugs and/or over-the-counter drugs, vitamins and inhalers)

Name of Drug	Strength	Frequency taken	Date started

Allergies

List each of the medication that you are allergic to, and the reaction that you experienced from taking the medications:

Name of Drug	Reaction You Had

Social Habits

Occupation: _____ If retired, previous occupation: _____

Alcohol use:

☐ Never ☐ Occasionally ☐ Frequently ☐ Daily

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____

If you previously smoked, when did you quit? date _____

Family History

Family Member	Problem	Age diagnosed	Age at death