



200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: 269.373.7478
www.wmcc.org

ADMINISTRATIVE

HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Attending Physician (Office Use) _____

Individual completing this form (Relationship to patient) _____

GENERAL INFORMATION

Patient Full Name: _____ Social Security #: _____ Date of Birth: _____ Age: _____

Emergency Contact Name / Relationship: _____ Phone: _____

Family Physician: _____ Referring Physician: _____

Other Physicians: _____

Type of Insurance: _____

Primary Insurance Holder Name / Relationship (You / Spouse/ etc): _____

Insurance Holder: Social Security #: _____ Date of Birth: _____

Do you have a Durable Power of Attorney for Health Care/Appointment of a Patient Advocate? Y N

If yes, did you bring a copy with you? Y N Court Ordered Legal Guardian? Y N

Email address: _____ Hospital Preference (labs, scans, admissions): Borgess Bronson

Educational Level:

- Less than High School High School / GED Some College
2 yr College Degree 4 yr College Degree Master's Degree
Doctoral Degree Professional Degree (MD, JD)

Can you read? Y N

Can you write? Y N

Primary Language? _____ Will you need a free translator? Y N

Will you be bringing your own translator with you? Y N

Marital Status

- Married Partner Divorced Widowed Separated Single

Adopted Y N If yes, history known? Y N

Twin? Y N If yes: Identical Fraternal

Race:

- Black / African American Pacific Islander / Hawaiian Native Other
American Indian / Alaskan White / Caucasian Do not wish to provide
Asian Unknown

Ethnicity:

- Hispanic or Latino Non-Hispanic or Latino Unknown
Do not wish to provide Other

PAST MEDICAL HISTORY

WMCC # _____

Has a doctor ever told you that you have any of the following conditions?

Check Yes or No for each condition.

Cancer / Treatment for cancer

Previous cancer	Y	N
Type _____		
Radiation therapy	Y	N
Chemotherapy	Y	N
Hormone therapy for cancer	Y	N
Radiation for non cancer	Y	N

Cardiovascular

High blood pressure	Y	N
Heart murmur	Y	N
Stroke	Y	N
Rheumatic Fever	Y	N
Angina	Y	N
Heart attack	Y	N
Heart failure	Y	N
Irregular Rhythm	Y	N

Eyes

Cataracts	Y	N
Glaucoma	Y	N

Ear/Nose/Throat/Mouth

Goiter of thyroid	Y	N
Hearing Difficulty	Y	N

Respiratory

Asthma	Y	N
Chronic bronchitis	Y	N
Emphysema	Y	N
Tuberculosis	Y	N

Endocrine

Diabetes	Y	N
Hyperthyroidism	Y	N
Hypothyroidism	Y	N

Skin

Scleroderma	Y	N
Psoriasis	Y	N

Gastrointestinal

Crohn's disease (enteritis)	Y	N
Ulcerative colitis	Y	N
____ # Polyps in rectum/ colon		
Hernia	Y	N
Intestinal bleeding	Y	N
Ulcer	Y	N
Gallstones	Y	N
Jaundice/ Hepatitis	Y	N
Cirrhosis of liver	Y	N
Pancreatitis	Y	N
Spastic colon/Irritable colon	Y	N

Genitourinary

Kidney stones	Y	N
Bladder leakage	Y	N
Bladder prolapse	Y	N
MEN-Prostate problems	Y	N

Blood Diseases

Collagen vascular disease	Y	N
Anemia	Y	N
Stroke	Y	N
Other blood disorders	Y	N
Blood Clots in legs or lungs (DVT/PE)	Y	N

Musculoskeletal

Osteoarthritis	Y	N
Rheumatoid arthritis	Y	N
Gout	Y	N
Osteoporosis	Y	N

Other

Lupus	Y	N
Metal fragment in your body	Y	N
If yes, Where? _____		
HIV Positive (AIDS)?	Y	N

Screenings: Month / Year of last:	Where Done?	By Whom?	Abnormal?
Colonoscopy			Y N
Mammogram			Y N
Pap Smear			Y N

Y=Yes N=No

PAST SURGICAL HISTORY	YES / NO	Age	Hospital / City-Surgery Performed
Cataract Surgery: L R	Y N		
Heart: Coronary Artery Bypass	Y N		
Heart Stent / Replacement	Y N		
Heart Valve Replacement	Y N		
Pacemaker	Y N		
Serial #	Model #		
Hip/Knee Replacement: L R	Y N		
Gall Bladder	Y N		
Tonsils	Y N		
Appendix	Y N		

	YES / NO	Age	Hospital / City-Surgery Performed
MEN			
Prostate Surgery	Y N		
Vasectomy	Y N		
WOMEN			
Breast Biopsy L R	Y N		
Breast Removal (Mastectomy) L R	Y N		
Lumpectomy L R	Y N		
Tubal Ligation	Y N		
Hysterectomy	Y N		
Ovary Removal L R	Y N		

List all other surgeries	Age	Hospital / City-Surgery Performed

OB-GYN HISTORY			
At what age did you have your first period?		Have you been diagnosed with endometriosis?	Y N
How many pregnancies have you had?		Have you ever been diagnosed with fibroids?	Y N
How many babies have you delivered?		Have you ever had an abnormal pap smear?	Y N
How many vaginal deliveries?		Have you ever taken birth control pills?	Y N
How many c-sections?		How many years?	
How many miscarriages / abortions?		Have you ever used hormone replacement therapy?	Y N
At what age did you go through menopause?		How many years?	

REVIEW OF SYSTEMS

Do you now or have you had any problems within the last 6 months related to the following systems?
Check Y (YES) or N (No) for each symptom.

Gastrointestinal

Abdominal pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Indigestion	Y	N
Heartburn	Y	N
Diarrhea	Y	N
Constipation	Y	N
Dark stools	Y	N
Bright red bleeding	Y	N
Problems chewing	Y	N
Swallowing	Y	N

Hematologic / Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Loss of smell	Y	N
Ringing in ears	Y	N

Endocrine

Excessive thirst	Y	N
Too hot / Cold	Y	N
Tired / Sluggish	Y	N

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Coughing up of blood	Y	N
Hay fever	Y	N

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N

Constitutional Symptoms

Fever	Y	N	
Chills	Y	N	
Headache	Y	N	
Night sweats	Y	N	
Hot flashes	Y	N	
Loss of appetite	Y	N	
Loss of taste	Y	N	
Recent weight loss	Y	N	_____ #lbs
Recent weight gain	Y	N	_____ #lbs
How much water do you drink in a day?	_____		
Other:	_____		

Musculoskeletal

Change in height	Y	N
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness / tingling	Y	N
Location	_____	
Memory changes	Y	N

Skin

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Genitourinary

Not able to urinate	Y	N
Pain when urinating	Y	N
Urinating frequently	Y	N
Urinate at night	Y	N
# of times	_____	

Psychologic

Are you happy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered harming yourself?	Y	N
Have you ever been on or are you currently taking anti-depressants / anxiety medications?	Y	N
Have you been hospitalized for any psychiatric /mental health reason?	Y	N

FAMILY HISTORY

How many children do you have? ____ daughters ____ sons

How many siblings do you have? ____ brothers ____ sisters

How many siblings does/did your mother have? ____ brothers ____ sisters

How many siblings does/did your father have? ____ brothers ____ sisters

Are you of Ashkenazi Jewish descent? Y N

Has anyone in your family had cancer? Y N

If yes: Please fill out the table below. Be sure to tell us if anyone has had more than one type of cancer.

Relationship (e.g. mother, father, etc.)	M / F	Check One		Type(s) of Cancer	Age at diagnosis	Fill in one column	
		Father's Side	Mother's Side			Current Age	If deceased, age at death
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Did anyone in your family die before age 40? Y N

If yes: Please fill out the table below.

Relation of the deceased (e.g. father's sister)	Age at death	Cause of death
1.		
2.		
3.		



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ADMINISTRATIVE

RELEASE OF HEALTH CARE INFORMATION

I authorize West Michigan Cancer Center & Institute for Blood Disorders to release the following healthcare information regarding:

(Patient's Name - Printed)

(Patient's Date of Birth)

Purpose of disclosure: (i.e. individual's request, insurance, continuing care)

This authorization will expire (if neither box is checked, authorization will expire 12 months after its execution):

Indefinitely

Specific Date: _____

Information is to be released to: (Name and relationship of who is authorized to receive information)

Table with 3 columns: Name, Relationship, Phone Number. Multiple empty rows for data entry.

In order to protect our patients, specific authorization is required to release certain information. If any of the following apply, and you wish to have that information released, you must place your initials on the line next to the appropriate line:

- _____ Treatment of emotional illness, including documentation by a social worker, psychologist/psychiatrist (does not include psychotherapy notes)
• _____ Treatment of alcohol or substance abuse
• _____ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex
• _____ Treatment of venereal disease, tuberculosis or communicable disease as specified by the MI Department of Public Health

This authorization may be revoked at any time by notifying the organization in writing at WMCC, Privacy Officer, 200 N. Park St, Kalamazoo, MI 49007, but this will not affect disclosures made prior to receipt of the revocation.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization. Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to redisclosure by the recipient and will no longer be protected by laws.

By signing this Authorization, I acknowledge that I have read it and that I understand it.

Signed: _____ (Date)

Description of Authorized Representative's Authority to Sign: _____



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NUTRITION

NUTRITION SCREENING FORM

Name: _____ Date of Birth: _____

In compliance with The American College of Surgeon’s Commission on Cancer, the West Michigan Cancer Center (WMCC) provides you with free services regarding information on nutrition and diet changes through treatment. This form will be reviewed by your physician and a registered dietitian to coordinate appropriate services for quality care.
Please print clearly to ensure timely response to your needs.

Height: _____
 Weight: _____
 Have you had recent unintentional weight loss in the past month? Y N
 If yes, how much? _____
 Have you had any recent unintentional weight loss in the past six months? Y N
 If yes, how much? _____

Have you experienced any of the following problems in the past month?

1. Vomiting lasting more than three days?	Y	N
2. Diarrhea (more than three liquid stools per day)?	Y	N
3. Loss of appetite or nausea?	Y	N
4. Difficulty or pain with chewing or swallowing?	Y	N

Do you currently have a feeding tube? Y N
 If yes, for how long? _____
 Who do you receive your supplies from? _____
 Are you currently receiving TPN (nutrition through your vein)? Y N
 If yes, for how long? _____
 Who do you receive your supplies from? _____

➤ **WMCC Staff Processing: Original document to physician, copy to registered dietitian.** ◀