

**PATIENT HISTORY QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Stated Height: \_\_\_\_\_ Stated Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Interpreter Needed?  No  Yes If yes, for which language? \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Tel #: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
 Physician performing procedure: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Internist: \_\_\_\_\_ Last seen: \_\_\_\_\_ Oncologist: \_\_\_\_\_ Last seen: \_\_\_\_\_

**ALLERGIES and ALLERGY REACTIONS:**

LIST PREVIOUS SURGERIES:	Year	Complications	Type of Anesthesia
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**MEDICATIONS: List medication name only; no dosage information is needed.**

(Includes over-the-counter, herbal remedies, inhalers, eye drops, or recreational drugs)

1	5	9
2	6	10
3	7	11
4	8	12

Please check appropriate box in each section below:

<b>CARDIOVASCULAR</b>	Yes	No		Yes	No
Hypertension/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack – Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pain or shortness of breath when walking	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	2 blocks or climbing 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation in lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias i.e. A-Fib	<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/AICD	<input type="checkbox"/>	<input type="checkbox"/>	(age of onset)		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Father		
Heart Valve problems	<input type="checkbox"/>	<input type="checkbox"/>	Mother		
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Siblings		
Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		

<b>PULMONARY</b>	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in lungs or legs	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Bronchitis/Emphysema (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Use @ _____ L/min	<input type="checkbox"/>	<input type="checkbox"/>
Asbestos Exposure	<input type="checkbox"/>	<input type="checkbox"/>			

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**Gamma Knife**



<b>EYES, EARS, NOSE, THROAT</b>		Yes	No		Yes	No	
Abnormal vision		<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both sides				New lumps	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss		<input type="checkbox"/>	<input type="checkbox"/>	Location: _____			
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both sides							
<b>GASTROINTESTINAL</b>		Yes	No	<b>GENITOURINARY</b>		Yes	No
Hiatal Hernia		<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections		<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/GERD/Gastric Reflux (circle)		<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones		<input type="checkbox"/>	<input type="checkbox"/>
Gallstones		<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disease		<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease		<input type="checkbox"/>	<input type="checkbox"/>	Penile Prosthesis		<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A, B or C		<input type="checkbox"/>	<input type="checkbox"/>	Dialysis		<input type="checkbox"/>	<input type="checkbox"/>
Nausea		<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence		<input type="checkbox"/>	<input type="checkbox"/>
Vomiting		<input type="checkbox"/>	<input type="checkbox"/>	Colostomy/Ileostomy/Foley catheter		<input type="checkbox"/>	<input type="checkbox"/>
Constipation		<input type="checkbox"/>	<input type="checkbox"/>				
Diarrhea		<input type="checkbox"/>	<input type="checkbox"/>				
<b>HEMATOLOGIC</b>		Yes	No	<b>ENDOCRINE</b>		Yes	No
Anemia		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders		<input type="checkbox"/>	<input type="checkbox"/>	Oral/Insulin Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Blood Diseases i.e. Leukemia		<input type="checkbox"/>	<input type="checkbox"/>	Hypo/Hyperthyroidism		<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions		<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia		<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising		<input type="checkbox"/>	<input type="checkbox"/>	Pituitary		<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGIC</b>		Yes	No	<b>MUSCULOSKELETAL</b>		Yes	No
Stroke/TIA's		<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis		<input type="checkbox"/>	<input type="checkbox"/>
Seizures; Describe: _____		<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain Treatment		<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis		<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck Pain		<input type="checkbox"/>	<input type="checkbox"/>
Paralysis		<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness		<input type="checkbox"/>	<input type="checkbox"/>	Fall risk		<input type="checkbox"/>	<input type="checkbox"/>
Headache		<input type="checkbox"/>	<input type="checkbox"/>	Balance difficulty		<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizziness		<input type="checkbox"/>	<input type="checkbox"/>	Assistive device:			
Numbness/Tingling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Walker			
Depression		<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis: <input type="checkbox"/> Left <input type="checkbox"/> Right			
Memory problems		<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____			
<b>GENERAL HEALTHCARE</b>		Yes	No			Yes	No
Rashes; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs/alcohol?		<input type="checkbox"/>	<input type="checkbox"/>
Healing incisions; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	Type: _____			
Sores; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	Have you had:			
Extremity Swelling; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency/HIV		<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections		<input type="checkbox"/>	<input type="checkbox"/>	Measles/Mumps/Rubella (circle)		<input type="checkbox"/>	<input type="checkbox"/>
Porta cath; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox		<input type="checkbox"/>	<input type="checkbox"/>
PICC line; Location: _____		<input type="checkbox"/>	<input type="checkbox"/>	MMR Vaccine		<input type="checkbox"/>	<input type="checkbox"/>
Last flush: _____				Flu Vaccine – Date: _____		<input type="checkbox"/>	<input type="checkbox"/>
<b>Social History:</b>				Pneumonia Vaccine – Year: _____		<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? Amount: _____		<input type="checkbox"/>	<input type="checkbox"/>	TB Skin Test		<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown			
Did you ever smoke? Years: _____		<input type="checkbox"/>	<input type="checkbox"/>	<b>If female: possibility of pregnancy?</b>		<input type="checkbox"/>	<input type="checkbox"/>
Have you smoked in the past 12 months?		<input type="checkbox"/>	<input type="checkbox"/>	Last menstrual period: _____			
				Other: _____		<input type="checkbox"/>	<input type="checkbox"/>

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**Gamma Knife**

**SURGICAL INFORMATION**

Do you have any specific needs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Living alone	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise? Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have caps, bridges, dentures or loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>

Do you need information on:	Yes	No
Current surgery	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>
Activities	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	<input type="checkbox"/>
History of Malignant Hyperthermia (MH)	<input type="checkbox"/>	<input type="checkbox"/>
Family history of anesthesia problems or MH (circle)	<input type="checkbox"/>	<input type="checkbox"/>

**CANCER HISTORY**

History of Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes: Primary site: _____		
Cancer site: _____		
Oncologist: _____		
Last Pet or CT scan date: _____		
Imaging Center: _____		
Prior radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
If Yes: Site treated: _____		
Facility: _____		
Prior chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
If Yes: Last treatment: _____		
Facility: _____		
Are you taking blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>

**PAIN HISTORY**

Current pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes: <input type="checkbox"/> New onset <input type="checkbox"/> Chronic		
If Chronic, do you receive chronic pain treatment? If Yes, by whom: _____	<input type="checkbox"/>	<input type="checkbox"/>
Location of pain: _____		
Cause of pain: _____		
Describe pain: _____		
Intensity level: _____ (0=no pain, 10= most severe)		
Does pain radiate?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes: Where? _____		
Time of onset: _____		
What relieves the pain? _____		
Goal for pain relief: _____		

**DIETARY/FUNCTIONAL STATUS**

Recent weight loss or gain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special or restricted diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with swallowing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeding tube?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How do you manage these self care activities?		
	Independent	Needs assistance
Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>

Amount: \_\_\_\_\_  
Describe: \_\_\_\_\_  
Describe: \_\_\_\_\_  
# of \_\_\_\_\_ cans of \_\_\_\_\_ /per day

Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
[Patient/Parent/Conservator/Guardian] [If completed by other than patient, indicate relationship] [Date]

**THIS SECTION FOR HOAG FACILITY PERSONNEL USE ONLY**

\_\_\_\_\_  
[Reviewed by Assessment Nurse] [Date] [Time] [Reviewed by Procedure Nurse] [Date] [Time]