Appointment Date: _____ Patient Name: _____

COMPREHENSIVE CANCER CENTERS

Margaret Terhar, MD, FACS
Patient Questionnaire

Patient Name: _____ Age: _____ Date: _____

Referred by: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Cardiologist: _____ Phone: _____

Other Physician(s): _____

Pharmacies: _____ Phone: _____
Cross Streets: _____

Reason for visit: _____

Screening Exams

Date of last mammogram: _____
Other imaging studies (i.e. CT scan, MRI, PET): _____
Where do you have your scan/imaging studies done? _____

Smoking History

Have you ever smoked? Yes: Current Past No:
If yes, age when you started: _____ Age when you quit: _____
Average packs per day: _____ Date quit: _____

Have you ever had chemotherapy? If so, give date and place: _____

Have you ever had radiation therapy? If so, give date and place: _____

Personal history of cancer? _____

Medical History

Please check if you have a history of, or currently have any of the following:

	Yes	No		Yes	No
Anemia			Hemorrhoids		
Anxiety			Hiatal Hernia		
Arrhythmias			High Cholesterol		
Arthritis			Hypertension		
Asthma			Hyperthyroidism		
Bipolar Disorder			Hypothyroidism		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots			Kidney Failure		
Bronchitis			Kidney Stones		
Cataracts			Migraines		
Cohn's Disease			Multiple Sclerosis		

Colitis		
Congestive Heart Failure		
Dementia		
Depression		
Diabetes		
Diverticular Disease		
Emphysema (COPD)		
Fibromyalgia		
Gastritis		
GERD		
Heart Attack		
Heart Murmur		

Osteopenia		
Osteoporosis		
Parkinson's Disease		
Peptic Ulcer Disease		
Pulmonary Embolism		
Seizures		
Sleep Apnea		
Stroke		
Thyroid Disease		
Urinary Tract Infections		
Valvular Disease		

Surgery History *(please include all breast biopsies as well)*

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Blood Transfusions: Yes No

Family History

Family Member	List Any Cancers	Age of Diagnosis	Living Illness/Age	Deceased Cause/Age
Father				
Mother				
Brothers				
Sisters				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				
Other Family				

Social History

Marital Status: single married divorced widowed separated

Are you currently: employed retired unemployed on disability

Occupation: _____

Do you drink alcohol? Yes No If yes, what type? _____

How much per week? _____

Did you ever drink large amounts of alcohol? Yes No Date quit (if applicable): _____

Any use of recreational drugs? _____ Type: _____

OB/GYN History

Age of first period: _____ Date of last menstrual period: ____ Age of Menopause: _____

Are you currently pregnant? _____ # Pregnancies: _____ # Live births _____

Age at first pregnancy: _____ Age at first live birth: _____

Currently breast feeding? Yes No

History of birth control of hormone replacement? Yes No

If yes, how long were you on the medication: _____ Name of medication: _____

Please check if you CURRENTLY have any of the following symptoms*

	Yes	No		Yes	No
Fatigue			Nausea/Vomiting		
Weight Gain			Constipation		
Weight Loss			Diarrhea		
Vision Changes			Burning with Urination		
Sinusitis			Blood in Urine		
Ringing in the ears			Irregular Periods		
Sore Throat			Painful Periods		
Chest Pain			Muscle Pain		
Palpitations			Back Pain		
Ankle Swelling			Skin Rash		
Cough			Depression		
Shortness of Breath/Wheezing			Anxiety		
Heartburn			Hot Flash Menopausal		
Abdominal Pain			Hot Flash Unrelated to Menopause		

Allergies

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Current Medications

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Office Use Only
Date: _____ MA: _____

COMPREHENSIVE CANCER CENTERS

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES FOR NEVADA

ATTENTION: If you speak any of the following languages, language assistance services, free of charge, are available to you. Call 1-877-261-6608 for more information.

Amharic:	**Arabic**
ትኩረት: እርስዎ የ አሜርኛ ተናጋሪ ከሆኑ የ ቋንቋ ድጋፍ አገልግሎቶች ያለ ክፍያ በነጻ ተዘጋጅልዎታል:: በ1-877-261-6608 ይደውሉ::	ملحوظة: إذا كنت تتحدث اللغة العربية، تتوافر لك خدمة المساعدة اللغوية بالمجان. برجاء الاتصال بـ 1-877-261-6608.
Chinese:	**French:**
注意：如果您讲中文，我们可以为您提供免费语言协助服务。请拨打 1-877-261-6608。	ATTENTION : Si vous parlez français, des services d'aide linguistique, vous sont proposés gratuitement. Appelez le 1-877-261-6608.
German:	**Ilocano:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-877-261-6608.	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan iti 1-877-261-6608.
Japanese:	**Korean:**
ご注意：日本語でお話しになりたい場合は、無料の言語支援サービスをご利用いただけます。1-877-261-6608にお電話ください。	안내: 한국어 통역지원서비스를 무료로 제공해드리고 있습니다. 지원이 필요하시면, 전화 1-877-261-6608로 문의하시기 바랍니다.
Russian:	**Samoan:**
ВНИМАНИЕ: Если вы говорите по-русски, вам предложены бесплатные услуги перевода. Звоните по телефону 1-877-261-6608.	FAAALIGA: Afai e te tautala Faa-Samoa, o loo maua fesoasoani mo tautua tau gagana, e lē totogia mo oe. Telefoni i le 1-877-261-6608.
Spanish:	**Tagalog:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llamar al 1-877-261-6608.	ATENSYON: Kung nagsasalita ka ng Tagalog, ang mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit mo. Tumawag 1-877-261-6608.
Thai:	**Urdu:**
โปรดทราบ: หากคุณพูดภาษาไทย บริการให้ความช่วยเหลือด้านภาษาพร้อมให้บริการแก่คุณโดยไม่มีค่าใช้จ่าย โทร 1-877-261-6608	**توجہ: اگر فارسی صحبت می‌کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می‌گیرد. با 1-877-261-6608 تماس بگیرید.**
Vietnamese:	
CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi 1-877-261-6608.	