John Wayne Cancer Center
Dermatological Center for Skin Health
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JOHN WAYNE CANCER INSTITUTE
at Saint John's Health Center

Medical Questionnaire **Date: ___________**

Name: ____ Gender: Male Female Age: ________
Last First Middle
Birth-date: _________ Birth Place: ___________________ Mother's Birth Name: _________________
Social Security Number: ______ - _____ - _______ Driver's License #: _________________________
Marital Status: Single Married ~ Spouse's Name ___________________________________
Married how long?____________ Divorced Separated Widowed
Language Spoken:_____________________ Interpreter Required? Yes No
Home Address: ____
City: __________________________________ State: __________ Zip-code: ___________-_________
Phone: _________________________________Fax: ____

Employer: ____________________________________ Occupation: ___________________________
Address: ____ Phone: _______________________
City: __________________ State: _____ Zip-code: _________-_______ Fax: ____________________

Emergency Contact: ____________________________ Relationship: __________________________
(Not living in the same household)
Address:____
City: ____ State: ________ Zip-code: _________-_____

Phone: _______________________________ Fax: ___________________________________

Local Telephone Number: (Relative, Friend or Hotel) _______________________________________

1. Primary Care Physician: ____
   Specialty: ____
   Address: ____
   City: _______________________________________ State: _________Zip-code: _________-_____
   Phone: ____________________________________ Fax: __________________________________

2. Referring Physician (if other than #1): ____
   Specialty: ____
   Address:____
   City: ______________________________________ State: __________Zip-code: __________-____
   Phone: ___________________________________ Fax: ____________________________________

3. Other Physician:____
   Specialty: ____
   Address:____
   City: ______________________________________ State: __________Zip-code: __________-____
   Phone: ___________________________________ Fax: ____________________________________

Patient Name: ______________________

ALLERGIES:

Category	*Yes*	*No*	*Do Not Know*	*List Specific item (for example. sulfa, eggs, dust mites)*	*What happens (for example, rash, swelling, itchy eyes)?*
Drugs					
Food					
Environmental					

PRESENT ILLNESS:

Please describe in your own words the date of onset of your illness, symptoms & treatment.

How long have you had symptoms? Are they constant or do they come and go?

What makes it worse?

Has anything made it better?

Patient Name:________________________

Please indicate if you **currently are experiencing** any of the following. If you are not sure, please mark "Do Not Know" and we will be happy to assist you during your scheduled visit.

GENERAL

	Condition	YES	NO	Do Not Know
1.	Fever/Chills			
2.	Swollen or enlarged (lymph) glands			
3.	Weight Changes (loss or gain)			
4.	Night sweats (soaking the sheets)			
5.	Fatigue			
6.	Insomnia			
7.	Loss of appetite			
8.	Cancer			
9.	Infectious disease			
10.	Pain			

SKIN

	Condition	YES	NO	Do Not Know
1.	New or Changing moles			
2.	Birthmarks			
3.	New rashes			
4.	Sensitivity to the sun			

HEAD, EYES, EARS, NOSE THROAT - (HEENT)

	Condition	YES	NO	Do Not Know
1.	Headaches			
2.	Dizziness			
3.	Fainting spells			
4.	Vision problems			
5.	Double or blurred vision			
6.	Problems with hearing			
7.	Sinus trouble			
8.	Nose bleeding			
9.	Sore tongue			
10.	Bleeding gums			
11.	Unusual trouble with teeth			
12.	Recent cold or sore throat			
13.	Itchy eyes (Allergies)			
14.	Itchy nose (Allergies)			
15.	Dry eyes			

Patient Name:________________________

ENDOCRINE

	Condition	YES	NO	Do Not Know
1.	Thyroid problems			
2.	Heat or cold intolerance			
3.	Changes in hair or nails			
4.	Changes in skin texture			
5.	Bone disorders			
6.	Diabetes			

HEART

	Condition	YES	NO	Do Not Know
1.	Heart problems			
2.	Bruise easily or bleed easily			
3.	Bleeding problems			
4.	High blood pressure			
5.	Pressure in chest			
6.	Undue shortness in breath (day or night)			
7.	Ankle Swelling			
8.	Edema			
9.	Pain in legs while walking			
10.	Have you ever had a blood transfusion			
11.	Implanted device (Shunt, pump, pacemaker)			

PULMONARY

	Condition	YES	NO	Do Not Know
1.	Chronic cough			
2.	Coughed up blood			
3.	Soaking sweats			
4.	Exposure to TB			
5.	History of a positive TB test (PPD)			
6.	Asthma			
7.	Lung disease			

GASTROINTESTINAL

	Condition	YES	NO	Do Not Know
1.	Abdominal pain			
2.	Difficulty swallowing			

Patient Name:________________________

3.	Nausea or vomiting			
4.	Frequent bowel movements			
5.	Constipation			
6.	Recent change in bowel movements			
7.	Black bowel movements			
8.	Blood in stools			
9.	Jaundice			
10.	History of hepatitis (liver disease)			
11.	History of inflammatory bowel disease			

GENITOURINARY URINARY

	Condition	YES	NO	Do Not Know
1.	Kidney problems			
2.	Blood in urine			
3.	Testicular pain			

MUSCULOSKELETAL/IMMUNE

	Condition	YES	NO	Do Not Know
1.	Joint pain			
2.	Back or bone pain			
3.	Numbness or tingling of hands or feet			
4.	Muscle pain or weakness, sore muscles			
5.	Muscle spasms			
6.	History of autoimmune disease			
7.	Abnormal antibody tests			
8.	Immune problems			
9.	Color changes in fingers/toes (white, blue or red)			
10.	Blood disease			

NEUROLOGIC

	Condition	YES	NO	Do Not Know
1.	Excessive worry			
2.	Excessive depression			
3.	Nervous disorders			
4.	Slowed thinking, decreased concentration or decreased memory (out of ordinary)			
5.	Seizures			
6.	Tremors			
7.	Strokes			
8.	Trans Ischemic Attack (TIA)			
9.	Changes in your vision			

Patient Name:________________________

10.	Problems with bowel			
11.	Bladder control			
12.	Unsteady walking			
13.	Loss of balance			
14.	Headaches			
16.	History of anesthesia problems			
17.	Mental Illness			
18.	Family history of anesthesia problems			

HABITS

1.	Alcohol intake: Yes No Indicate next to each the amount of drinks and Frequency – i.e. Daily, Weekly or Monthly. 1. Beer 2. Wine 3. Whiskey 4. Other			
2.	Smoking: Cigarettes packs			
3.	Intravenous Drug use? Yes No			
4.	Other Drug use? (such as freebase cocaine) Yes No			
5.	Exercise If yes, type and frequency?			

PAST SURGERIES (Operations):
Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

OTHER HOSPITALIZATIONS:
Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

OTHER MEDICAL PROBLEMS:

Patient Name:________________________

Please list any medications/herbs/supplements you are taking, date that you started and the date you discontinued (if applicable).

Pain Pills:
Tranquilizers:
Sleeping Pills:
Antibiotics (recently):
High blood pressure medicine/water pills:
Medicine for cholesterol control:
Over the counter/non-prescription drugs/nutritional supplements (i.e. Aspirin, Tylenol, Motrin, Aleve,
Vitamins, Diet Pills, herbs, etc.):
Other medications:

FAMILY HISTORY:

Relation	***Age***	***State of Health***	***If deceased – Cause of Death***	***Age at Death***
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Patient Name:________________________

Have any of your *blood* relatives, husband, wife or children had any of the following?

YES	NO	(CHECK EACH ITEM)	RELATION(S)
		Tuberculosis	
		Diabetes	
		Cancer (Melanoma, Basal cell, Squamous cells, Merkel or other)	
		Autoimmune disease (Lupus, Dermatomyositis, Vitiligo, Pemphigus, Pemphigoid, Scleroderma)	
		Unusual moles (Atypical Nevus Syndrome, Giant Congenital Nevus)	
		Kidney Disease	
		Asthma, Hay Fever, Other Allergy	
		Chronic Arthritis (Rheumatism)	
		Multiple Sclerosis or Guillan Barre Syndreom	
		Nervous Or Mental Disorder	
		Any Other Illness (please specify):	

FITZPATRICK SKIN-TYPE - Please circle which describes you best.
Genetic Disposition

Score	***0***	***1***	***2***	***3***	***4***
What is the color of your eyes?	Light blue, Grey, Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non sun-exposed areas)?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	none

Patient Name:______________________

Reaction to Sun Exposure - Please circle which describes you best.

Score	***0***	***1***	***2***	***3***	***4***
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Classification Scale – Please circle which skin type fits you best.

Skin Type	***I***	***II***	***III***	***IV***	***V***	***VI***
Skin Color	White; very fair; red or blond hair; blue eyes; freckles	White; fair; red or blond hair; blue, hazel, or green eyes	Cream white; fair with any eye or hair color; very common	Brown	Dark Brown	Black
Characteristics	Always burns, never tans	Usually burns, tans with difficulty	Sometimes mild burn, gradually tans	Rarely burns, tans with ease	Very rarely burns, tans very easily	Never burns, tans very easily

RECENT TRAVEL:

Dates	Location	Unusual exposures

Patient Name:_______________________

Certain diseases are more common in specific genetic backgrounds. Please indicate your ethnicity:

- ☐ Caucasian
- ☐ Black or African American
- ☐ Non-African Black
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Other: _________________