



**JOHN WAYNE
CANCER INSTITUTE**
at Saint John's Health Center

JOHN WAYNE CANCER INSTITUTE
AT ST. JOHN'S HEALTH CENTER

**LIVER AND PANCREAS CENTER
GASTROINTESTINAL SURGERY**

HEALTH QUESTIONNAIRE

NAME: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

DATE OF SURGERY _____ PAST SURGICAL HISTORY (Type of Surgery) _____

PAST MEDICAL HISTORY	Yes	No	Don't Know
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/ Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY to Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENERAL			
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEENT			
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser treatment for the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharyngitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in the Sputum/ while coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			
Nausea and Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in the stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENITO-URINARY			
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysuria- burning while urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematuria- Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OB-GYN			
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular/ Excessive Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULO-SKELETAL	Yes	No	Don't Know
Muscle pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DERMATOLOGIC			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGIC			
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEURO			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes or Transient Ischemic Attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alteration in sleep/appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyper or Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICABLE DISEASE			
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB Tuberculosis now or in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL HISTORY			
Do you smoke? When did you last smoke- _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink Alcohol? When was your last drink- _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use drugs & when was the last time? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY			
Married	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children- Number: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your father alive? Cause of demise if not alive- _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mother alive? Cause of demise if not alive- _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have your brother or sisters got any medical problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____			
Have your brother or sisters got any medical problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____			