GREENVILLE HEALTH SYSTEM
Cancer Institute
Center for Integrative Oncology & Survivorship

Greenville Health System
Center for Integrative Oncology and Survivorship
Health History Questionnaire

Please complete this questionnaire to the best of your ability BEFORE you come in. Your answers will help us identify Survivorship needs with you. Pease call us at 864-455-1346 with any questions.

Patient Name:	**Date:**

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer

Race: ☐ Black ☐ White ☐ Multi-racial ☐ Native American/Alaskan Native ☐ Asian-Pacific Islander ☐ Decline To Answer

Date Of Birth: (/ /)	**Age:**
Support contact name:	
Support contact relationship:	**Support contact phone**:

HEALTH CARE TEAM (INCLUDE PRIMARY CARE & SPECIALISTS)

Name	Specialty	Phone

MEDICAL HISTORY
Prior Diagnosis/Disease (i.e. Cancer, high blood pressure, diabetes, high cholesterol, etc.)

SURGICAL HISTORY

Surgery	Date	Reason	Surgeon

FAMILY HISTORY

Family Member	Disease/Type of Cancer	Living (Y/N)

GREENVILLE HEALTH SYSTEM
Cancer Institute
Center for Integrative Oncology & Survivorship

Greenville Health System
Center for Integrative Oncology and Survivorship
Health History Questionnaire

GENETIC COUNSELING	
Have you had genetic counseling?	Where/When?
Have you had genetic blood testing?	Where/When?

ALLERGIES	
Medication/Food	Reaction/Comments

HEALTH MAINTENANCE		
Test/Exam	Date	Provider/Comments
Cholesterol		
Skin Check		
Bone Density		
Colonoscopy		
Men: Prostate Exam/PSA		
Women: Gynecologic Exam		
Women: Mammogram		
Adult Vaccines: Influenza		
Pneumovax		
Zostavax		

SOCIAL HISTORY	
Married ___ Divorced ___ Partnered ___ Single ___ Widowed ___	Number of children: Number of grandchildren: Pets:

Do you currently or have you ever smoked?	Yes		No = Lifetime Nonsmoker
	# of years	How many per day?	
Cigarettes			
Cigars			
Pipe			
Chew/snuff			
Do you drink alcohol?	Never	Socially	Daily
How many per day/week?			
What type?			
# of years?			
Do you have a history of alcohol or drug abuse?	Yes	No	
Have you ever been exposed to hazardous materials?	Yes	No	
What type?			
For how long?			
Do you exercise?	Yes	No	Sometimes
What type?			
How often?			
How many minutes per session?			

GREENVILLE HEALTH SYSTEM
Cancer Institute
Center for Integrative Oncology & Survivorship

Greenville Health System
Center for Integrative Oncology and Survivorship
Health History Questionnaire

Review of Systems
Please take a moment to tell us how you are doing

PHYSICAL					
CNS/ENT:	Yes	No	**Cardiovascular:**	Yes	No
Severe Headaches			Irregular Heartbeat		
Dizziness			Pace Maker		
Memory Changes			Heart Attack		
Numbness or Tingling			Chest Pain/Angina		
Hearing Loss			Heart Murmur		
Dry Eyes			Congestive Heart Failure		
Eyes Watering			Ankle Swelling		
Respiratory:			**Musculoskeletal:**		
Shortness of Breath			Bone Pain		
Prescribed Oxygen			Joint Pain		
Cough			Difficulty Walking		
Hoarseness			Lymphedema		
Digestive System:	Yes	No	**Genitourinary:**	Yes	No
Nausea			Frequent Urination		
Taste Changes			Urinary Incontinence		
Stomach burning/upset			Kidney Stones		
Difficulty Swallowing			Sexual Intimacy		
Decreased Appetite			Males: Erectile Difficulties		
Weight Loss/Gain			Females: Vaginal Dryness		
Hemorrhoids					
Blood in stool					
Endocrine:					
Thyroid Problems					
Tremors-Shakes					
Weakness					
Night Sweats					
Trouble Sleeping					
PSYCHOSOCIAL					
Psychological:	Yes	No	**Social:**	Yes	No
Anxiety			Relationship Difficulties		
Depression			Work Issues		
Fear of Recurrence			Financial		
“New Normal”					
Feeling Overwhelmed					
Spiritual:					
Loss of Faith					
Living with Uncertainty					

GREENVILLE HEALTH SYSTEM
Cancer Institute

Center for Integrative Oncology & Survivorship

Greenville Health System
Center for Integrative Oncology and Survivorship
Health History Questionnaire

MEDICATION LIST (PRESCRIPTION and OTC)			
►***Please bring a complete list of all prescription & OTC medications to your appointment. Include dose, schedule, & prescriber.***◄			
MEDICATION	**DOSE**	**SCHEDULE**	**PRESCRIBER**

Revised 6/4/14 JAM