HOPE
CANCER CARE of NEVADA

Patient Name:_____DOB_____

Health History Questionnaire

Medications

List all medicines that you are currently taking (Include prescribed drugs and/or over the counter drugs, vitamins and Inhalers)

Name of Drug	Strength	Frequency taken	Date started

Pharmacy

Name	address	Zip code	Phone number

Allergies

List each of the medication that you are allergic to, and the reaction that you experience from taking the medications:

Name of Drug	Reaction You Had

Past Medical History

_____
_____
_____
_____
_____

Social Habits

Occupation:_____ If retired , pervious occupation:_____

Alcohol use:

( ) Never ( ) Occasionally ( ) Frequently ( ) Daily

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Do you smoke? ( ) Never
( ) In the past _____ # of years smoked _____ # of cig a day
( ) Current _____ # of years smoked _____ # of cig a day

Please list history of Cancer or Blood disorder in First degree Relatives.

_____

_____

_____

Past Surgical History

List major Surgeries you have had:

Surgery	**Date**

Hospitalization in the last 2 years.

Reason	**Date**