GENE UPSHAW MEMORIAL
TAHOE FOREST CANCER CENTER

HEALTH HISTORY QUESTIONNAIRE

Patient Name (First, MI, Last)	**DOB**

Medical History

Question	Yes	No	Date first noted (approximate)	Comments
No Past Medical History	☐			If Yes, skip to next page
Allergic rhinitis	☐	☐		
Anemia	☐	☐		
Aortic valve disorder	☐	☐		
Atrial fibrillation	☐	☐		
Congestive heart failure	☐	☐		
High blood pressure	☐	☐		
High cholesterol	☐	☐		
Mitral valve disorder	☐	☐		
Deep vein thrombosis (DVT or PE)	☐	☐		
Diabetes Mellitus	☐	☐		
Thyroid disorder	☐	☐		What type? _____
Esophageal Reflux	☐	☐		
Peptic ulcer	☐	☐		
Inflammatory bowel disease	☐	☐		
Hepatitis	☐	☐		
Chronic kidney disease	☐	☐		
Kidney stone	☐	☐		
Gout	☐	☐		
Fracture	☐	☐		Which bones? _____
Migraine Headaches	☐	☐		
Epilepsy (Seizures)	☐	☐		
Cancer	☐	☐		What type? _____
Glaucoma	☐	☐		
Bipolar disorder	☐	☐		
Depression	☐	☐		
Asthma	☐	☐		
Chronic obstructive lung disease	☐	☐		
Sleep apnea	☐	☐		
Osteoarthritis	☐	☐		
Rheumatoid arthritis	☐	☐		
Other:	☐			
Other:	☐			

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Surgical History

Question	Yes	No	Date (approximate)	Comments (indicate side where appropriate)
No Previous Surgeries	☐			If Yes, skip to next page
Appendectomy	☐	☐		
Breast Biopsy	☐	☐		
Cesarean Section	☐	☐		
Coronary Artery Bypass Graft (CABG)	☐	☐		
Coronary Stent	☐	☐		
Hernia Repair	☐	☐		
Hip Replacement	☐	☐		
Hysterectomy	☐	☐		
Knee Arthroscopy	☐	☐		
Knee Replacement	☐	☐		
Mastectomy	☐	☐		
Prostatectomy	☐	☐		
Tubal Ligation	☐	☐		
Colectomy	☐	☐		Complete or Partial? _____
Gastric Bypass	☐	☐		
Thyroidectomy	☐	☐		Complete or Partial? _____
Carotid Endarterectomy	☐	☐		
Oophorectomy (Ovaries Removed)	☐	☐		
Breast Augmentation	☐	☐		
Breast Reduction	☐	☐		
ACL Reconstruction	☐	☐		
Carpal tunnel release	☐	☐		
Laminectomy (Back Surgery)	☐	☐		What part of the back? _____
Fracture Repair	☐	☐		What part of the body? _____
Rotator Cuff Repair	☐	☐		
Shoulder Arthroscopy	☐	☐		
Transurethral Resection Prostate (TURP)	☐	☐		
Vasectomy	☐	☐		
Tonsillectomy	☐	☐		
Cataract Removal	☐	☐		
Other:	☐			
Other:	☐			

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Patient Name (First, MI, Last)	**DOB**

Family History

Instructions: Indicate heath status and major medical problems for close family members. Circle maternal or paternal if appropriate. If more space is needed, use the back side of this page and check this box. ☐	**Status**					**Cardiovascular**					**Cancers**						**Other**							
	Alive	**Deceased**	**Unknown**	**Age (or Age at Death)**	**Healthy**	**Heart Disease**	**Diabetes: Type 1 or 2**	**Hypertension**	**Stroke**	**High Cholesterol**	**Breast Cancer**	**Colon Cancer**	**Lung Cancer**	**Melanoma**	**Ovarian Cancer**	**Other _____**	**Osteoporosis**	**Asthma**	**Kidney Disease**	**Thyroid Disease**	**Liver Disease**	**Respiratory Disease**	**Anemia**	**Depression**
Father	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aunt (Maternal/Paternal)	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uncle (Maternal/Paternal)	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you of Ashkenazi or Sephardic Jewish descent? ☐ Yes ☐ No Describe your Family Ancestry/Ethnicity_____