

UCLA Thoracic Surgery
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MEDICAL HISTORY QUESTIONNAIRE

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PERSONAL DATA:

Please answer the following questions:

Name: _____

Today's date: _____

Street: _____

Age: _____ Birthdate: _____

City: _____

Birthplace: _____

State: _____ Zip Code: _____

E-mail address: _____

Home Telephone: (____) _____

UCLA I.D. number: _____

Work Telephone: (____) _____

Insurance source/policy no: _____

REFERRING PHYSICIANS:

Please check one of the following boxes and provide information on all physicians involved in your care:

- I was referred by one of my physician(s) below
 I referred myself with my physician's knowledge

- I was referred for a second opinion by my physician
 I referred myself without my physician's knowledge

Name: _____

Name: _____

Street: _____

Street: _____

City: _____

City: _____

State: _____ Zip Code: _____

State: _____ Zip Code: _____

Telephone Number: (____) _____

Telephone Number: (____) _____

Send reports to this physician _____

Send reports to this physician

Name: _____

Name: _____

Street: _____

Street: _____

City: _____

City: _____

State: _____ Zip Code: _____

State: _____ Zip Code: _____

Telephone Number: (____) _____

Telephone Number: (____) _____

Send reports to this physician

Send reports to this physician

PRESENT ILLNESS:

Please briefly describe the date of onset of your illness, your symptoms and all tests/treatment you have received:

SYMPTOMS:

I have NEVER experienced any of the symptoms below

Please indicate if you have now or have ever experienced any of the following? (Check all that apply):

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> New/changing cough | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Chest pressure/tightness |
| <input type="checkbox"/> Phlegm/sputum production
<input type="checkbox"/> clear <input type="checkbox"/> white <input type="checkbox"/> green
<input type="checkbox"/> brown <input type="checkbox"/> bloody | <input type="checkbox"/> Food "sticking" | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Hoarseness/change in voice | <input type="checkbox"/> Pain with swallowing | <input type="checkbox"/> Fast/irregular heart beats |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Regurgitation of food | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers/stomach trouble | <input type="checkbox"/> Difficulty breathing at night |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Difficulty breathing lying flat |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Weight loss: _____ lbs. | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of breath with exertion | <input type="checkbox"/> Weight gain: _____ lbs. | <input type="checkbox"/> Weakness/fatigue |
| <input type="checkbox"/> Shortness of breath at rest | <input type="checkbox"/> Fever | <input type="checkbox"/> Pain/aches in joints |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Other: _____ |

CURRENT MEDICATIONS:

Currently, I am NOT taking ANY medications

Please list ALL medications, doses, and frequencies (i.e., twice a day, every 8 hrs, etc.) below:

<u>Name</u>	<u>Dose</u>	<u>How often?</u>	<u>Name</u>	<u>Dose</u>	<u>How often?</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I sometimes take over the counter medications containing Aspirin (Anacin, etc.).

I sometimes take over the counter medications containing Ibuprofen (Advil, Motrin, etc.).

MEDICATION/FOOD ALLERGIES:

I have NO known food or drug allergies

Please list ALL allergies and reactions to medications and food:

<u>Medication/Food</u>	<u>Reaction:</u>
_____	_____
_____	_____
_____	_____

SUBSTANCE USE:

Please answer the following questions:

Tobacco:Do you now, or have you ever smoked cigarettes? Yes No

At the most, how many packs of cigarettes did/do you smoke each day? _____ packs

At what age did you start smoking? _____ years

Are you currently smoking? Yes No If no, at what age did you quit? _____Do you now, or have you ever smoked cigars, or a pipe? Yes NoDo people close to you smoke? Yes NoHow soon after you wake up do you start smoking? Within 30 min. After 30 minHow interested are you in stopping smoking? Not at all A little somewhat very interested

If you decided to quit smoking during the next 2 weeks, how confident are you that you would succeed?

 Not at all A little somewhat very confident**Alcohol:**Do you now, or did you ever drink alcohol? Yes No

If yes, how much beer do you, or did you drink? _____/day

How much wine do you, or did you drink? _____/day

How much hard liquor do you, or did you drink? _____/day

During the last week, on how many days did you have a drink? _____ days

When was the last time you drank an alcoholic beverage? _____

Have you ever felt bad or guilty about your drinking? Yes NoHave you ever had to have a drink in the morning to steady your nerves? Yes NoHave you ever had black-outs or memory loss? Yes NoHave you ever had seizures or the "DT's"? Yes No**Other:**Do you drink coffee? Yes No

If yes, how many cups each day do you drink? _____

Have you ever been exposed to asbestos? Yes No

If yes, when were you exposed? _____

How were you exposed? _____

Have you ever used any drugs such as marijuana, cocaine, amphetamines? Yes No

If yes, which one(s): _____ when was the last time used: _____

Have you ever injected drugs (such as heroin, or cocaine), into your veins? Yes No

If yes, which one(s): _____ when was the last time used: _____

PREVIOUS SURGERY: I have NEVER had an operation of any kind

Please list ALL operations you have had including: tonsils, appendix, hemorrhoids, hysterectomy, prostate surgery, etc:

<u>DATE</u>	<u>OPERATION</u>	<u>HOSPITAL</u>	<u>SURGEON</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY: I have NEVER experienced any of the symptoms below

Please indicate if you have now or have ever been told that you have any of the following? (Check all that apply):

- | | |
|--------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Abnormal Treadmill test | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Angina/chest discomfort or pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney Problem |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

HOSPITALIZATIONS: I have NEVER been hospitalized for any reason

Please list all hospitalizations excluding those for uncomplicated child birth:

<u>DATE</u>	<u>ILLNESS</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RADIATION THERAPY: I have NEVER received radiation therapy of any kind

Please list any prior radiation treatments you have received:

<u>START DATE</u>	<u>STOP DATE</u>	<u>BODY AREA TREATED</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CHEMOTHERAPY: I have NEVER received chemotherapy of any kind

Please list any chemotherapeutic agents you have received:

<u>START DATE</u>	<u>STOP DATE</u>	<u>AGENTS (IF KNOWN)</u>	<u>HOSPITAL</u>	<u>PHYSICIAN</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY HISTORY: I have no knowledge of any of my living or deceased relatives

Please record the state of health of your close blood relatives, i.e., mother, father, sisters, brothers, aunts, uncles, and grandparents:

<u>RELATIVE</u>	<u>ALIVE? YES/NO</u>	<u>HEALTH PROBLEMS/CAUSE OF DEATH</u>	<u>AGE NOW/AT DEATH</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Grandfather	_____	_____	_____
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Grandmother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Please indicate if **ANY** of your blood relatives has/had any of the following conditions (check all which apply):

<u>HEALTH PROBLEM</u>	<u>RELATIVES AFFECTED:</u>	<u>HEALTH PROBLEM:</u>	<u>RELATIVES AFFECTED:</u>
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Anemia/unusual bleeding	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney problems	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Liver problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Strokes	_____
<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart trouble	_____	<input type="checkbox"/> Other: _____	_____

SOCIAL HISTORY:Please complete the following questions as **COMPLETELY** as possible:Marital Status: Single Married/Partnered Divorced WidowedEmployment history: Currently employed Occupation: _____ Employer: _____ Unemployed Retired (Date): _____ Disabled (Date): _____

Previous Occupation: _____

What level of education have you attained? Grade school High School College ProfessionalHave you traveled outside the U.S? No Yes If yes, Where? _____ When? _____Have you ever served in the military? No Yes If yes, Which branch? _____With whom do you live _____ I live aloneDo you have difficulty dressing yourself? No YesDo you have difficulty carrying a 10 lb. bag or shopping? No YesHave you ever fallen at home? No Yes If yes, When? _____Are you receiving any special help at home? No Yes If yes, Who helps you? _____Do you follow any special diet? No Vegetarian Kosher Low fat Other: _____

GYNECOLOGIC/OBSTETRICAL HISTORY (WOMEN ONLY):

Please answer the following questions:

Gynecologic History:

At what age did you begin menstruating? _____ years

What is/was the interval between your menstrual periods? _____ days/weeks

What is/was the duration of your menstrual periods? _____ days

What is/was the date that your last period began? _____

Have you stopped having menstrual periods? No Yes If so, when? _____

Have you ever had irregular, painful, or heavy menstrual periods? No Yes

Have you ever had bleeding between periods or after menopause? No Yes

Do you have problems with vaginal discharge, pain, or itching? No Yes

Do you have "hot flashes"? No Yes

Have you ever had an abnormal Pap smear? No Yes If so, when? _____

When was your most recent Pap smear? _____

When was your most recent Pelvic exam? _____

Have you ever had a Mammogram? No Yes If so, date of last exam? _____

How often do you examine your breasts? Never Monthly Other _____

Would you like instruction in breast self-examination? No Yes

Obstetrical History:

Have you ever been pregnant? No Yes If so, number of times: _____

How many children have you delivered? _____

How many miscarriages have you had? _____

How many abortions have you had? _____

Are you currently using any form of birth control? No Yes If so, what type? _____

Have you ever used birth control pills? No Yes If so, for how long? _____

Have you had a hysterectomy? No Yes If so, when? _____

Have you had your ovaries removed? No Yes If so, when? _____
 One ovary Both ovaries

Are you now or have you ever been on estrogen(hormone)replacement? No Yes

REVIEW OF SYSTEMS:

Please indicate if you have now or have ever experienced any of the following symptoms (Check all that apply):

<u>SYMPTOM</u>	<u>WHEN</u>		<u>SYMPTOM</u>	<u>WHEN</u>	
Infections			Hemorrhoids	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Mumps	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Jaundice	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
German measles	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Hepatitis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rheumatic fever	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Cirrhosis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rubella	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Liver problems	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Mononucleosis.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Blood transfusions.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Polio	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Gallbladder trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Malaria	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Urine		
Typhoid fever.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Blood in urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Shingles	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Sugar in urine	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Gonorrhea.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Albumin/protein in urine	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Syphilis	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Cloudy urine.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Skin			Kidney stones.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Rashes	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Prostate (men only)		
Tumors/unusual moles	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Slow urine stream.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Psoriasis/eczema (circle one).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Urination at night: (# of times __).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Hair loss	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Circulation/Vascular		
Eye			Leg pain with walking	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Eye infection/pink eye.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Poor circulation.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Blurred vision	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Varicose veins	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Cataracts.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Muscles/Joints		
Glaucoma	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Back/bone pain.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Ears			Arthritis/rheumatism.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Earache/discharge from ear(s).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Joint pains/deformity/redness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Ringing in the ears	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Pain with weather changes.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Spinning sensation/vertigo.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Finger changing colors.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Hearing loss.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Drainage from joints.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Nose and Mouth			Locking joints.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Sinus trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Muscle aches/stiffness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Nosebleeds.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Motion limitation.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Bleeding gums	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Reproduction		
Sore tongue	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Pain with intercourse	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Teeth trouble	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Impotence/loss of libido.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Lymph			Neurological		
Lumps in groin(s).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Paralysis	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Neck swelling	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Numbness/tingling of feet/hands	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Lumps in armpits	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Difficulty walking	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Breasts			Coordination problem/clumsiness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Lumps/pain in breast(s)	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Speech/memory problems.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Nipple discharge	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Loss of bowel/bladder control.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Gastrointestinal			Dizziness/fainting spells	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Ulcers/stomach trouble.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Epilepsy/seizures	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Black/tarry bowel movements.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Psychological		
Bright red bowel movements.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Excessive worry/nervousness.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Unusual constipation:.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Depression/nervous disorder.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Unusual diarrhea	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Personality disorder	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Change in stool size	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Endocrine		
Change in stool color	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Thyroid problems	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Change in stool frequency	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Head/cold intolerance (circle one).....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Indigestion/"gas"	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Unusual thirst/appetite.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past
Abdominal pain.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past	Hand/foot swelling/enlargement.....	<input type="checkbox"/> Now	<input type="checkbox"/> In Past

TO BE FILLED OUT BY PHYSICIAN:**PHYSICAL EXAM:**

Wt. ___ kg Ht. ___ BP ___ HR ___ RR ___ Temp ___ °C O₂ Sat (RA/ ___ L/min) ___ %

- General:** appears younger older equal to the patient's stated age
 appears in no mild moderate severe acute distress
- Eyes:** pupils are equal and reactive anisocoric sluggish Other: _____
 sclera are anicteric mildly icteric moderately icteric unequally icteris ___ > ___
- Ears:** appears normal otorrhea bloody
- Nose:** appears clear rhinorrhea hemorrhage masses
- Throat:** appears clear bleeding gums poor dentition pharyngitis mass: location: _____
- Neck:** supple lymphadenopathy: left/ right; thyromegaly Other masses: _____
- Back:** CVA tenderness: left/ right; spinal tenderness: location: _____
- Lungs:** clear rales: left/ right; rhonchi: left/ right; wheezing: left / right;
 dullness to percussion: left/ right; vocal fremitus: left/ right; egophony
- Heart:** rate/rhythm: regular/ irregular; PMI in the 5th ICS murmur: grade: I/ II/ III/ IV,
 systolic/ diastolic/ other, radiation: to _; ↑S1 ↑S2; pericardial friction rub
- Abd:** appears: soft scaphoid distended: mildly/ moderately/ severely; nontender
 tender: location _____ hepatosplenomegaly masses: location _____
- Vascular:** carotid: Right: 1+ 2+ 3+ 4+ bruit; Left: 1+ 2+ 3+ 4+ bruit
 radial: Right: 1+ 2+ 3+ 4+ bruit; Left: 1+ 2+ 3+ 4+ bruit
 femoral: Right: 1+ 2+ 3+ 4+ bruit; Left: 1+ 2+ 3+ 4+ bruit
 pedal: Right: 1+ 2+ 3+ 4+ bruit; Left: 1+ 2+ 3+ 4+ bruit
- Ext:** clubbing: 1+ 2+ 3+ 4+; cyanosis: 1+ 2+ 3+ 4+;
 LE edema: Right: 1+ 2+ 3+ 4+; Left: 1+ 2+ 3+ 4+
- Rectal:** deferred without masses mass: locations: _____ occult blood
- Prostate:** deferred normal size enlarged without nodule(s) nodular
- Neuro:** cranial nerves: intact deficiencies: _____ motor: intact deficiencies: _____
 sensory: intact deficiencies: _____ proprioception: intact deficiencies: _____
- Psych:** orientation: X4/ person/ place/ time/ situation; reacts: appropriate/ inappropriate
- Skin:** normal suspicious nevi/lesions: location(s) _____ rashes: location(s) _____

IMAGING EXAM:

Chest CT: lung: RUL/ RML/ RLL/ LUL/ LLL; mediastinum esophagus chest wall
 other _____; mass fluid infiltrate adenopathy

PET Scan:

Bone Scan:

Head MRI:

PFT:

Other:

PRIMARY EVALUATION:

Note dictated by _____ Note dictated at _____ Dictation number _____

ASSESSMENT: