BRAIN TUMOR CENTER AT SAINT JOHN'S

PATIENT QUESTIONNAIRE

Name: ____ **Date:** _________________________________

Your phone numbers: *Home*_______________ *Cell:*_______________ **E-Mail address:** ____________________

Emergency contact person:_________________________________ *Phone number*:___________________________

I came to see Dr. Kelly and the BTC by: ___ **Referral from another physician (name):**______________________

___ **Referral from a friend or another patient (name):**________________

___ **My own research (explain):**_________________________________

___ **Other:**____

Prior to seeing Dr. Kelly I went online and reviewed the BTC Website ___Yes ___No

Why are you seeing Dr. Kelly? ____

What are your symptoms related to this problem?

1.

2.

3.

4.

Have you been diagnosed with other medical problems?

☐ High blood pressure ________________________

☐ High Cholesterol/ Hyperlipidemia ______________

☐ Lung disease/Asthma _______________________

☐ Gastro-intestinal problems___________________

☐ Depression__________________________________

☐ Seizures__________________________________

☐ Cancer – type?_____________________________

☐ Heart disease (Heart attack):__________________________

☐ Diabetes____

☐ Thyroid problems__________________________________

☐ Kidney disease/Dialysis______________________________

☐ Alzheimer's/Parkinson's disease_______________________

☐ Stroke____

☐ Other issues:_______________________________________

Please list any past surgeries and the year performed:

1.

2.

3.

Which doctors are you currently seeing? Which doctors need a copy of today's consultation note from Dr. Kelly?

1.

2.

3.

4.

MEDICATIONS

Are you taking any medications? Y ☐ N ☐ If YES please list below:

1.

2.

3.

4.

5.

6.

ALLERGIES: Do you have any allergies to medications? Y ☐ N ☐

If YES please list below and describe your reaction to the medication:

1.

2.

3.

4.

2200 Santa Monica Boulevard, Santa Monica, CA 90404

Phone: 310-582-7450 • Fax: 310-582-7495 • WWW.BRAIN-TUMOR.ORG

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SOCIAL HISTORY

☐ Married ☐ Single ☐ Children? Number: ___________

Are you currently employed? ______________ Current position? ______________________________

Are you disabled ? ___________ How long? ______________________________

Do you drink alcohol? _____ If yes, how often? ____________ Do you smoke? _____ If yes, how often? _____________

FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

☐ Heart disease (Heart attack)_________________

☐ High blood pressure _________________

☐ Lung disease/Asthma _________________

☐ Kidney disease/Dialysis _________________

☐ Diabetes _________________

☐ Thyroid problems _________________

☐ Depression_________________

☐ Alzheimers/Parkinson's disease _________________

☐ Seizures_________________

☐ Stroke_________________

☐ Cancer – type?_________________

☐ Other issue:_________________

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

General

Y	N	Don't Know	
☐	☐	☐	Fever, chills, sweats
☐	☐	☐	Loss of appetite, weight loss

Eyes

Y	N	Don't Know	
☐	☐	☐	Eye irritation/ infection
☐	☐	☐	Glaucoma/ cataract/ eye surgery
☐	☐	☐	Wear glasses/ contacts
☐	☐	☐	Difficulty urinating, blood in urine

ENT/ Mouth

Y	N	Don't Know	
☐	☐	☐	Earache/ ringing
☐	☐	☐	Sinusitis, runny nose, allergies
☐	☐	☐	Oral ulcerations

Respiratory

Y	N	Don't Know	
☐	☐	☐	Asthma, emphysema/bronchitis
☐	☐	☐	Cough
☐	☐	☐	Recent chest x-ray
☐	☐	☐	Tuberculosis

Cardiovascular

Y	N	Don't Know	
☐	☐	☐	Short of breath
☐	☐	☐	Irregular heart beat

Psychiatric

Y	N	Don't Know	
☐	☐	☐	Depression
☐	☐	☐	Anxiety disorder

Gastrointestinal

Y	N	Don't Know	
☐	☐	☐	Nausea/ vomiting
☐	☐	☐	Diarrhea/ constipation/ bloody stools
☐	☐	☐	Heartburn/ indigestion/reflux disease
☐	☐	☐	Polyps/colonoscopy

Genitourinary

Y	N	Don't Know	
☐	☐	☐	Increased urination

Musculoskeletal

Y	N	Don't Know	
☐	☐	☐	Leg cramps
☐	☐	☐	Arthritis/ arthralgias/ gout
☐	☐	☐	Soft tissue/ bony trauma
☐	☐	☐	Congenital deformity

Skin

Y	N	Don't Know	
☐	☐	☐	Leg ulcers/ discoloration of feet/legs
☐	☐	☐	Bruising/ bleeding tendencies
☐	☐	☐	Acne

Reproductive

Y	N	Don't Know	
☐	☐	☐	Normal periods
☐	☐	☐	Absent periods
☐	☐	☐	Irregular periods
☐	☐	☐	Post-menopausal
☐	☐	☐	Pre-menopausal
☐	☐	☐	Hysterectomy

Please sign below:

Patient Signature:_____________________________

Affix Patient Label Here