

# 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. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Have you been diagnosed with other medical problems?

High blood pressure \_\_\_\_\_  Heart disease (Heart attack): \_\_\_\_\_

High Cholesterol/ Hyperlipidemia \_\_\_\_\_  Diabetes \_\_\_\_\_

Lung disease/Asthma \_\_\_\_\_  Thyroid problems \_\_\_\_\_

Gastro-intestinal problems \_\_\_\_\_  Kidney disease/Dialysis \_\_\_\_\_

Depression \_\_\_\_\_  Alzheimer's/Parkinson's disease \_\_\_\_\_

Seizures \_\_\_\_\_  Stroke \_\_\_\_\_

Cancer – type? \_\_\_\_\_  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. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

### MEDICATIONS

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

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

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

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

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

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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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Heart disease (Heart attack) _____ | <input type="checkbox"/> High blood pressure _____            |
| <input type="checkbox"/> Lung disease/Asthma _____          | <input type="checkbox"/> Kidney disease/Dialysis _____        |
| <input type="checkbox"/> Diabetes _____                     | <input type="checkbox"/> Thyroid problems _____               |
| <input type="checkbox"/> Depression _____                   | <input type="checkbox"/> Alzheimers/Parkinson's disease _____ |
| <input type="checkbox"/> Seizures _____                     | <input type="checkbox"/> Stroke _____                         |
| <input type="checkbox"/> Cancer – type? _____               | <input type="checkbox"/> Other issue: _____                   |

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

**General**

- |                          |                          |                          |                               |
|--------------------------|--------------------------|--------------------------|-------------------------------|
|                          | Don't                    |                          |                               |
| Y                        | N                        | Know                     |                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever, chills, sweats         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite, weight loss |

**Eyes**

- |                          |                          |                          |                                 |
|--------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye irritation/ infection       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma/ cataract/ eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses/ contacts          |

**ENT/ Mouth**

- |                          |                          |                          |                                  |
|--------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Earache/ ringing                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis, runny nose, allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oral ulcerations                 |

**Respiratory**

- |                          |                          |                          |                              |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, emphysema/bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cough                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent chest x-ray           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                 |

**Cardiovascular**

- |                          |                          |                          |                      |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Short of breath      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |

**Psychiatric**

- |                          |                          |                          |                  |
|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety disorder |

**Gastrointestinal**

- |                          |                          |                          |                                       |
|--------------------------|--------------------------|--------------------------|---------------------------------------|
|                          | Don't                    |                          |                                       |
| Y                        | N                        | Know                     |                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/ vomiting                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea/ constipation/ bloody stools |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/ indigestion/reflux disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polyps/colonoscopy                    |

**Genitourinary**

- |                          |                          |                          |                                      |
|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased urination                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating, blood in urine |

**Musculoskeletal**

- |                          |                          |                          |                              |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/ arthralgias/ gout |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soft tissue/ bony trauma     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congenital deformity         |

**Skin**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leg ulcers/ discoloration of feet/legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruising/ bleeding tendencies          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne                                   |

**Reproductive**

- |                          |                          |                          |                   |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Normal periods    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Absent periods    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-menopausal   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pre-menopausal    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hysterectomy      |

**Please sign below:**

Patient Signature: \_\_\_\_\_

**Affix Patient Label Here**