

**PATIENT HEALTH QUESTIONNAIRE**

Appt. Date \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

FOR OFFICE USE ONLY- Medical Record #: \_\_\_\_\_ HRBC #: \_\_\_\_\_

**What is the main reason for your visit to the Breast Cancer Prevention Center?**

\_\_\_\_\_  
\_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

**1. Racial Categories: (May select more than one)**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White (includes Hispanic or Latino)

**2. Ethnic Categories:**

- Hispanic or Latino
- Not Hispanic or Latino

**3. Ashkenazi Jewish Descent?**

- No
- Yes
- Unknown

**PATIENT SOCIAL HISTORY**

**4. What is your current marital status ? (Select One)**

- Single
- Married
- Partnered
- Divorced
- Widowed

**5. Education level completed: (Select one)**

- High school/GED
- Some college or associate’s degree
- Graduate/professional school
- Vocational/technical school beyond high school
- College
- Other: \_\_\_\_\_

**6. Current occupation:** \_\_\_\_\_

**7. What is your current employment status ? (check the one that most applies to you)**

- Employed full-time
- Homemaker
- Disabled
- Employed part-time
- On medical leave
- Other: \_\_\_\_\_
- Retired
- Unemployed and/or seeking work

**8. Are you a student?**

- No
- Yes IF YES, are you:
  - Full-time
  - Part-time

**9. Please check the best approximate income level range of your household**

- Less than \$20,000
- \$20,000 to \$40,000
- \$40,000 to \$60,000
- \$60,000 or over

**LIFESTYLE**

**10. Have you ever smoked?**

- No, never
- Yes, currently
- Yes, but only in the past

If **Yes**, on average, how many cigarettes do you or did you smoke **per day**? \_\_\_\_\_

At what age did you **START** smoking? \_\_\_\_\_ years old

If you quit, at what age did you **STOP** smoking? \_\_\_\_\_ years old

**Total number of years as a smoker?** \_\_\_\_\_ **years**

**11. Have you ever or do you currently drink alcohol?**

- No, never
- Yes, currently
- Yes, but only in the past

If **Yes**, currently or in the past, how many alcoholic beverages (beer, wine, mixed drinks, etc.) do you consume per month? (drink is equal to one mixed/hard liquor drink or one beer)

Average # of drinks per month: \_\_\_\_\_

**12. Do you exercise regularly?**

- No
- Yes

Please indicate the total average # of hours per week you exercise: \_\_\_\_\_

What is the typical type of exercise that you do regularly? \_\_\_\_\_



**17. Have you ever had a breast cyst aspirated?**

- No  Yes

If yes, explain: \_\_\_\_\_

**18. Have you ever had breast cancer?**

- No  Yes

If yes, did you receive other types of treatment for your breast cancer and what were the approximate dates?

Type of treatment	Check all that apply	Date of Treatment (mm/yyyy)	Duration of Treatment
Radiation therapy			
Chemotherapy			
Antihormonal therapy (i.e. Nolvadex (tamoxifen), Evista (raloxifene), Femara (letrozole), Arimidex (anastrozole))			

**19.**

**ALLERGIES**

**Do you have any allergies? (include medication, environmental, chemical, latex, betadine)**

- No  Yes

If yes, please indicate:

What you are allergic to:	What your reaction is:

**20.**

**GYNECOLOGIC HISTORY**

Menstrual History			
Age at first period			
# of pregnancies			
# of miscarriages			
# of live births			
Age at first live birth			
Have you breast fed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, what was the longest period of time you breast fed? _____ months	
Have you had a period in the past 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, are your periods regular? (every 28-35 days) Yes No Date of last menstrual period _____ (mm/dd/yyyy)
Was your last pelvic exam normal?	<input type="checkbox"/> No—if no, results: _____		<input type="checkbox"/> Yes Date of exam: _____ (mm/yyyy)
Have you had your ovaries removed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, which ovary(ies) removed? Left Right Both If yes, why? _____ Date of surgery _____ (mm/yyyy) Age _____
Have you had your uterus removed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, why? _____ Date of surgery _____ (mm/yyyy)



**BONE HEALTH**

25.

Have you had a bone mineral density?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, date _____ mm/yyyy
Do you have low bone mineral density? (osteoporosis/osteopenia)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Do you have a family history of osteoporosis in your family?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, list relatives:
Have you taken calcium supplements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dose _____ How long? ____ yrs.
Have you taken corticosteroids for an extended period of time? (i.e. prednisone, decadron)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, for what reason?

**HEART HEALTH**

26.

Have you ever had a fasting lipid profile? (e.g. cholesterol)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, date _____ mm/yyyy If yes, normal results? Yes No
Has anyone in your family had heart disease diagnosed under age 60? (hypertension, coronary artery disease, stroke, heart attack, etc.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, list relatives and approximate age at diagnosis:

**COLON CANCER RISK**

27.

Have you undergone a colonoscopy or flexible sigmoidoscopy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, date _____ mm/yyyy  If yes, normal results? Yes No Were any polyps removed? Yes No If polyps removed, what were the results? _____
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28.

**REVIEW OF SYSTEMS**

**Do you presently have any problems or symptoms in the following areas?**

**Circle N=NO or Y=YES below. If answer is “YES”, please give an explanation.**

<u>Menopausal Symptoms</u>	Circle One		Patient Comments: Circle One:	Clinician Comments:	
1. Hot flashes	N	Y	mild      moderate severe	0-10 score (10 is the worst)	
2. Vaginal dryness	N	Y	mild      moderate      severe		
3. Memory problems	N	Y	mild      moderate      severe		
4. Mood swings/irritability	N	Y	mild      moderate      severe		
5. Decreased sex drive	N	Y	mild      moderate      severe		
6. Hair loss/skin change	N	Y	mild      moderate      severe		
7. Weight Gain	N	Y	mild      moderate      severe		
8. Sleep disturbances/night sweats	N	Y	mild      moderate      severe		
<u>Constitutional</u>					
9. Good general health past year	N	Y			
10. Recent weight changes (more than 10 lbs.)	N	Y			
11. Recurrent fevers, chills, sweats	N	Y			
12. Fatigue	N	Y			
13. Stress	N	Y			
14. Pain	N	Y			
<u>Eyes</u>					
15. Wear glasses/contact lenses	N	Y			
16. Blurred or double vision	N	Y			
17. Change in vision	N	Y			
18. Glaucoma	N	Y			
<u>Ear/Nose/Mouth/Throat</u>					
19. Difficulty hearing	N	Y			
20. Ringing in the ears	N	Y			
21. Recent nose bleeds	N	Y			
22. Chronic sinus problems	N	Y			
23. Mouth sores	N	Y			
24. Bleeding gums	N	Y			
25. Frequent sore throats	N	Y			
26. Voice changes	N	Y			
27. Hoarseness	N	Y			
<u>Respiratory</u>					
28. Asthma or wheezing	N	Y			
29. Breathing problems	N	Y			
30. Chronic cough	N	Y			
<u>Cardiovascular</u>					
31. Murmur	N	Y			
32. Chest pain or angina	N	Y			
33. Shortness of breath	N	Y			
34. Palpitations	N	Y			
35. Swelling of feet, ankles or hands	N	Y			

<b>36. Blood clots (leg or lung)</b>	N	Y	
37. Varicose veins	N	Y	
38. High blood pressure	N	Y	
<b>39. Prior deep vein thrombosis (DVT)</b>	N	Y	
40. High Cholesterol	N	Y	
41. Coronary artery disease (clogged arteries)	N	Y	
42. Prior heart attack	N	Y	
43. Prior stroke	N	Y	
<u>Gastrointestinal</u>			
44. Change in appetite	N	Y	
45. Severe heartburn	N	Y	
46. Increase or decrease in weight	N	Y	
47. Frequent nausea/vomiting	N	Y	
48. Frequent diarrhea	N	Y	
49. Constipation/painful bowel movement	N	Y	
50. Black or bloody stools	N	Y	
51. Rectal bleeding	N	Y	
52. Rectal/Colon Polyps	N	Y	
<b>53. Ulcerative colitis</b>	N	Y	
54. Abdominal pain	N	Y	
<b>55. Bleeding ulcers</b>	N	Y	
<u>Genitourinary</u>			
56. Blood in the urine	N	Y	
57. Burning with urination	N	Y	
58. Vaginal dryness or painful intercourse	N	Y	
59. Sexually transmitted disease	N	Y	
60. Change in sexual function or interest	N	Y	
<u>Gynecologic</u>			
61. History of abnormal pap smear	N	Y	
<b>62. Cysts on the ovaries</b>	N	Y	
63. Fibroids in the uterus	N	Y	
<b>64. Endometriosis</b>	N	Y	
65. Abnormal uterine bleeding	N	Y	
66. Painful periods	N	Y	
<u>Integumentary (skin &amp; breasts)</u>			
67. Birth marks	N	Y	
68. Recurrent rashes	N	Y	
69. Changing moles	N	Y	
70. Skin cancer or melanoma	N	Y	
71. Non-healing wounds	N	Y	
72. Breast pain or lump	N	Y	
73. Fibrocystic breasts	N	Y	
74. Nipple discharge	N	Y	
75. Change in hair (loss or increase)	N	Y	
<u>Nervous System</u>			
76. Nervousness	N	Y	
77. Depression	N	Y	
78. Problems sleeping	N	Y	
79. Anxiety	N	Y	

80. Headaches	N	Y	
<b>81a. Migraine headache: frequent or severe</b>	N	Y	
<b>82b. Migraine associated with hormones (pregnancy/periods)</b>	N	Y	
83. Change in memory/concentration	N	Y	
84. Family history of Alzheimer's Disease	N	Y	
85. Numbness or tingling sensations	N	Y	
86. Weakness or paralysis	N	Y	
87. Other	N	Y	
<u>Musculoskeletal</u>			
88. Joint stiffness or pain	N	Y	
89. Muscle pain or cramping	N	Y	
90. Weakness of muscles or joints	N	Y	
91. Back pain	N	Y	
92. Difficulty walking	N	Y	
<u>Endocrine</u>			
93. Heat or cold intolerance	N	Y	
94. Excess thirst or urination	N	Y	
95. Diabetes	N	Y	
96. Arthritis (osteo, rheumatoid)	N	Y	
97. Over or under active thyroid	N	Y	
<u>Allergic/Immunologic</u>			
98. Low resistance to infection	N	Y	
99. Frequent cold or flu	N	Y	
100. Environmental allergies	N	Y	
101. Latex	N	Y	
102. Betadine	N	Y	
103. Epinephrine	N	Y	
<u>Hematologic/Lymphatic</u>			
104. Easy bruising	N	Y	
105. Frequent/difficulty stopping bleeding	N	Y	
106. Enlarged lymph nodes	N	Y	