Health History Questionnaire

We are dedicated to protecting your privacy. The information you provide on this form will be kept completely confidential and will be shared only with the class instructors.

Knight Cancer Institute
at Oregon Health & Science University

Name:____

Phone Number:________________________________ Emergency Contact:______________________________

Cancer type:_________________________________ Date of diagnosis:________________________________

Oncologist:___________________________________ Primary Care Physician:___________________________

Treatment Information

1) Did you have surgery for cancer? ☐ Yes ☐ No
   Date of surgery:________________________ Site of Surgery:______________________________
   Impairments from surgery (if any):____
   ____
   ____

2) Have you had any other surgeries not related to cancer (e.g. knee replacement)? ☐ Yes ☐ No
   Date of surgery:________________________ Site of Surgery:______________________________
   Impairments from surgery (if any):____
   ____
   ____

3) Did you have chemotherapy? ☐ Yes ☐ No
   Date of completion:_____________________ Name of chemotherapy: ______________________
   Do you have persistent side effects from chemotherapy? ☐ Yes ☐ No
   Please list any symptom(s) that is bothering you now that you believe could be related to your prior chemotherapy (e.g. numbness in fingers and toes, pain, depression):__________________________

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4) Did you have radiation therapy? ☐ Yes ☐ No
Site of radiation:_________________ Date of radiation completion:__________________________
Impairments or symptoms from radiation (if any):____
____
____

5) Are you taking any medications currently related to your cancer treatment (e.g.,antihormonal therapy for breast cancer [tamoxifen])? ☐ Yes ☐ No
Name of medication:____
Please list any symptom you have now that you believe is related to your medication: ___________
____
____
____

6) Are you taking any other medications unrelated to your cancer? ☐ Yes ☐ No
Please provide the names as best as you can remember them and what they are for
____
____
____
____

7) Please indicate if you have any of the following symptoms and describe, as necessary.

- ☐ Fatigue:____
- ☐ Depression:____
- ☐ Anxiety:____
- ☐ Difficulty sleeping: ____
- ☐ Weight gain or loss__:____
- ☐ Change in appetite:____
- ☐ Pain:____
- ☐ Shortness of breath: ____
- ☐ Edema:____
- ☐ Joint stiffness or pain (include any joint replacements or surgeries): ______________________
  ____
- ☐ Fractures:____
- ☐ Myalgias (muscle pain):____
- ☐ Muscle weakness: ____
- ☐ Lymphedema: ____
- ☐ Neuropathy:____
- ☐ Other:____

8) Please indicate if you have ever had the following health conditions and describe if necessary:

- ☐ Hypertension (high blood pressure):____
- ☐ High cholesterol:____
- ☐ Heart attack:____
- ☐ Congestive heart failure:____
- ☐ Stroke:____
- ☐ DVT (blod clot):____
- ☐ Diabetes:____
- ☐ Arthritis:____
- ☐ Osteoporosis:____
- ☐ Other:____

Is there anything else that you want the exercise instructor to know about you?

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