UCLA Health

NEW PATIENT HEALTH HISTORY FORM
UCLA BRAIN TUMOR CENTER

MRN:
Patient Name:

(Patient Label)

Chief Complaint

Reason for today's visit, please include date of any illness onset, as well as symptoms and any treatment:

_____

_____

Allergies / Contraindications

Have you ever had an allergic reaction to any medication (including IV contrast dye or iodine) or food? If yes, please list medication or food and reaction:

_____

_____

Medications

Please list any medications (prescription and over the counter) you are currently taking (including vitamins and aspirin):

Name & Reason	Dosage	Frequency Per Day

Preferred Pharmacy: _____

Street Address: _____

City, State, Zip Code:_____

Phone Number: _____ Fax Number: _____

Preferred Laboratory: ☐ UCLA ☐ Outside: _____

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Medical History

Have you ever been diagnosed with any of the following conditions?

Brain Tumor	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Memory Loss	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Confusion	☐ Yes	☐ No	Movement Disorder	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No	Neurocutaneous Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No	Seizure	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No	Syncope	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Palpitations	☐ Yes	☐ No	Toxic Exposure	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Tremor	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Vascular Disorder	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No	Ulcers or ulcerative colitis	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Inflammatory bowel disease	☐ Yes	☐ No	Claustrophobia	☐ Yes	☐ No

Other Medical Diagnoses: (Please list all medical conditions not listed above):

_____

_____

_____

Surgical History

Please list all previous operations/hospitalizations:

Type of Operation	Year & Hospital	Complications

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Family History

For example: Cancer, Depression, Diabetes, Epilepsy, Heart Disease, Hypertension, Memory Loss, Multiple Sclerosis, Muscle Weakness, Psychosis, Seizures, Stroke, Thyroid Disease, etc.

Family Member	Age (or age at death)	Living Yes	Living No	Medical Problems
Mother		☐	☐	
Father		☐	☐	
Sister		☐	☐	
Brother		☐	☐	
Maternal Aunt		☐	☐	
Maternal Uncle		☐	☐	
Paternal Aunt		☐	☐	
Paternal Uncle		☐	☐	
Maternal Grandmother		☐	☐	
Maternal Grandfather		☐	☐	
Paternal Grandmother		☐	☐	
Paternal Grandfather		☐	☐	
Child		☐	☐	
Child		☐	☐	
Child		☐	☐	

Other:

_____

_____

☐ Adopted ☐ Family History Unknown

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Social History

Tobacco Use: ☐ Yes ☐ No Stop Date: _____

Packs/Day ☐ ¼ Pack ☐ ½ Pack ☐ 1 Pack ☐ > 1 Pack

Years: ☐ < 1yr ☐ 1 – 5 yrs ☐ > 5 yrs ☐ years _____

Smokeless Tobacco? ☐ Yes ☐ No Stop Date: _____

Ready to stop: ☐ Yes ☐ No Stop Date: _____

Alcohol Use: ☐ Yes ☐ No Stop Date:_____

Drinks/Week:

Type	Frequency per Week
Glasses of Wine (5 oz.)	
Cans of Beer (12 oz.)	
Shots of Liquor (1.5)	
Drinks containing 1.5 oz. of alcohol	

Drug Use: ☐ Yes ☐ No

Type	Frequency per Week

Have you had significant exposure to:

Pesticides? ☐ Yes ☐ No

Toxic Waste? ☐ Yes ☐ No

Handedness: ☐ Right ☐ Left

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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Mobility History

1. Do you need help to transfer to a chair? ☐ Yes ☐ No
2. Do you use any assistive devices (cane, walker, wheelchair)? ☐ Yes ☐ No
3. Can you walk in your home with or without assistance? ☐ Yes ☐ No
4. Can you walk outside your home with or without assistance? ☐ Yes ☐ No
5. Have you had any falls within the last 3 months? ☐ Yes ☐ No
6. Has your current physical state been stable for:
   - 0-3 months? ☐ Yes ☐ No
   - 4-6 months? ☐ Yes ☐ No
   - More than 6 months? ☐ Yes ☐ No

Pain History

1. Do you now, or have you in the past, take medication for anxiety? ☐ Yes ☐ No
2. Do you use marijuana? ☐ Yes ☐ No
3. Do you have a history of drug abuse/ dependence (prescription medications, cocaine, amphetamines, heroin)? (This information is confidential but is important for your care during surgery)
   - ☐ Yes (Please list what drugs you use) _____
   - ☐ No
4. Do you now, or have you in the past, take any pain medications (other than Tylenol or Advil) on a regular basis?
   - ☐ Yes (Please list them) _____
   - ☐ No
5. Do you now or have you in the past had a problem with chronic pain (pain lasting longer than 3 months for which you sought the help of a physician)? ☐ Yes ☐ No
6. My pain is: ☐ Adequately Controlled ☐ Inadequately Controlled

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Treatment History

Please list any chemotherapy or radiation therapy treatments you have received:

Name of Drug/Regimen	Year & Hospital	Number of Cycles

1. Have you ever had a drug or platelet transfusion in the past? ☐ Yes ☐ No
   a. If Yes, what was the date of the most recent transfusion? _____
   b. If Yes, have you ever had a reaction to a transfusion? _____
2. Do you have a pacemaker? ☐ Yes ☐ No

Support Systems

1. Do you live alone? ☐ Yes ☐ No
2. Do you live with your spouse, significant other, family or friends? ☐ Yes ☐ No
3. Do you live in your own house/apartment? ☐ Yes ☐ No
4. Do you live in a nursing home? ☐ Yes ☐ No
5. Do you live in an assisted living environment? ☐ Yes ☐ No
6. Would transportation to UCLA for daily treatments be difficult for you? ☐ Yes ☐ No

a. If Yes, please explain:_____

For Female Patients Only:

1. Age at onset of menstruation _____
2. Age at onset of menopause (if postmenopausal) _____
3. Have you taken oral contraceptives or hormone replacement therapy? ☐ Yes ☐ No
   a. If yes, for how long? _____
   b. Name of therapy: _____
4. Have you ever taken birth control pills? ☐ Yes ☐ No
   a. If yes for how long? _____
5. Are you currently pregnant? ☐ Yes ☐ No
6. Number of pregnancies: _____
7. Number of live births: _____
8. Your age when your first child was born: _____
9. Date of last mammogram: _____
10. Date of last pap smear: _____

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Review of Systems:

Have you ever had any of the following illnesses or symptoms?

System	Check Yes or No	System	Check Yes or No
Allergy / Immunology		**Genitourinary**	
Low resistance to infection	☐ Yes ☐ No	Blood in urine or stool	☐ Yes ☐ No
Environmental or animal allergies	☐ Yes ☐ No	Burning with Urination	☐ Yes ☐ No
		Difficult/frequent urination	☐ Yes ☐ No
Reactions (runny nose, itchy eyes)	☐ Yes ☐ No	Lack of bladder or bowel control	☐ Yes ☐ No
Cardiovascular		Sexually transmitted disease	☐ Yes ☐ No
Chest pains or angina	☐ Yes ☐ No	Change in sexual function	☐ Yes ☐ No
Irregular heart rhythm	☐ Yes ☐ No	Frequent night time urination	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Sexual difficulty	☐ Yes ☐ No
Swelling of the feet, ankles, and hands	☐ Yes ☐ No	Urgency with urination	☐ Yes ☐ No
		Urine color change	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Female) Vaginal (discharge/bleeding)	☐ Yes ☐ No
Difficulty walking two blocks (dyspnea)	☐ Yes ☐ No	(Female) Vaginal spotting	☐ Yes ☐ No
Constitutional		(Male) Impotence	☐ Yes ☐ No
Good general health lately	☐ Yes ☐ No	(Male) Scrotal/testicular swelling	☐ Yes ☐ No
Recent weight changes	☐ Yes ☐ No		
Extreme fatigue	☐ Yes ☐ No	**Hematologic/Lymphatic**	
Recurrent fevers, chills, sweats	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No
		Frequent bleeding	☐ Yes ☐ No
Frequent nausea, vomiting	☐ Yes ☐ No	Enlarged lymph nodes	☐ Yes ☐ No
Difficulty sleeping	☐ Yes ☐ No	**Integumentary Skin & Breasts**	
Decreased appetite	☐ Yes ☐ No		
Malaise (uneasiness)	☐ Yes ☐ No	Unusual or prolonged rashes	☐ Yes ☐ No
Lethargy (sluggishness, sleepiness)	☐ Yes ☐ No	Breast pain or lump	☐ Yes ☐ No
		Change in hair or nails	☐ Yes ☐ No
Ears, Nose, Mouth, Throat		Blisters	☐ Yes ☐ No
Change in hearing	☐ Yes ☐ No	Abnormal itching (pruritus)	☐ Yes ☐ No
Ringing in the ears	☐ Yes ☐ No	**Musculoskeletal**	
Recent nose bleeds	☐ Yes ☐ No	Joint/muscle stiffness/pain or arthritis	☐ Yes ☐ No
Chronic sinus problems	☐ Yes ☐ No		
Voice changes	☐ Yes ☐ No	Weakness or disease of muscles or joints	☐ Yes ☐ No
Soreness in mouth, tongue or throat	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Bleeding in mouth or gums	☐ Yes ☐ No	Difficulty walking	☐ Yes ☐ No

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Ear pain	☐ Yes ☐ No	Stiff neck	☐ Yes ☐ No
Mouth dryness	☐ Yes ☐ No	Bone pain	☐ Yes ☐ No
Ear infection	☐ Yes ☐ No	Range of motion problems	☐ Yes ☐ No
Taste changes	☐ Yes ☐ No	**Neurological**	
Excessive sputum production	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Eyes		Numbness/tingling sensation	☐ Yes ☐ No
Wear glasses and/or contact lenses	☐ Yes ☐ No	Weakness or paralysis	☐ Yes ☐ No
		Convulsions or seizures	☐ Yes ☐ No
Change in vision	☐ Yes ☐ No	Change in memory/concentration	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No		
Blurred vision	☐ Yes ☐ No	Loss or blurring of vision or double vision	☐ Yes ☐ No
Double vision	☐ Yes ☐ No		
Endocrine		Blackouts/dizziness	☐ Yes ☐ No
Heat or cold intolerance	☐ Yes ☐ No	Memory loss or confusion	☐ Yes ☐ No
Excess thirst or urination	☐ Yes ☐ No	Other neurological problems	☐ Yes ☐ No
Menstrual irregularities	☐ Yes ☐ No	Decreased coordination/gait	☐ Yes ☐ No
Hot flashes	☐ Yes ☐ No	Speech difficulties	☐ Yes ☐ No
Gastrointestinal		Disorientation	☐ Yes ☐ No
Change in appetite	☐ Yes ☐ No	Insomnia	☐ Yes ☐ No
Severe heart burn	☐ Yes ☐ No	Motor weakness	☐ Yes ☐ No
Vomiting blood	☐ Yes ☐ No	Sensory problems	☐ Yes ☐ No
Frequent diarrhea	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	**Psychiatric**	
Black or bloody stools	☐ Yes ☐ No	Nervousness/anxiety	☐ Yes ☐ No
Abdominal pain, swelling or cramping	☐ Yes ☐ No	Depression	☐ Yes ☐ No
		Other	☐ Yes ☐ No
Change in bowel habits	☐ Yes ☐ No	**Respiratory**	
Heartburn or indigestion	☐ Yes ☐ No	Breathing/problems/shortness of breath	☐ Yes ☐ No
Hemorrhoids	☐ Yes ☐ No		
Nausea	☐ Yes ☐ No	Coughing up blood	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Chronic cough	☐ Yes ☐ No

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Referral Contact

Were you by referred by another physician? ☐ Yes ☐ No

Please fill out address completely. This is important to ensure proper communication with your physician.

Referring MD: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

If you have a primary care physician other than your referring physician, please complete the information below.

Name of MD: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Would you like the information from today's visit sent to a physician other than those listed above?

Name of MD: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

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Current Occupation: _____

Employer: _____

How long have you worked for your current employer? _____

Are you presently: ☐ Working ☐ Disabled ☐ Retired

If not currently working, when did you stop? _____

Is the chief complaint a result of a specific injury or accident? ☐ Yes ☐ No

Date of accident _____

Type of accident _____

Are you involved in litigation regarding this condition? ☐ Yes ☐ No

The above information is accurate to the best of my knowledge:

Patient or Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____

Date _____ Time _____