Mays Cancer Center
UT Health San Antonio MD Anderson Cancer Center

Patient Label

ESTABLISHED FOLLOW UP QUESTIONAIRE

Please complete the following questionnaire. Leave blank any parts you are unsure of, or do not wish to answer. Your answers will help with providing your care. We will review this form with you during your examination. All information will be kept confidential.

Patient Name: _____ **Date of Birth:** _____

Address (City, State & Zip Code): _____

Place of Birth: _____

What is a good contact number for the doctor to reach you? _____

Who is your Primary Doctor? _____

What Pharmacy do you use? _____ **Phone No. #:**_____

What is the reason for your visit today?

_____

_____

Tobacco Use: YES / NO **Type: Cigarettes / Pipe / Cigars** **No. per day?** _____ **No. of Years:** _____

Smokeless Tobacco: Never Used / Yes/No **Type: Snuff** (between lower lip and gum) **/Chew** (between cheek and gum)

Quit Date: _____ **Ready to Quit? YES / NO** **Counseling Given? YES or NO**

Alcohol Use: YES / NO **Illicit Drug Use: YES / NO** **Comments:**_____

Medications

Please see attached list and update any medications that you are currently taking. Please include the dosage and any Over the Counter drugs, hormones, Vitamins and Herbs.
If you have stopped taking any medications that are listed please add the date you stopped taking medication.

Have you had any new Allergies since your last visit? Yes / No

Allergy: _____ **Reaction:** _____

Patient Signature: _____ **Date:** _____