IEO
European Institute of Oncology

Surname_____

Name_____

Date of Birth _____ / _____ / _____

Sex _____ Age _____ years

MEDICAL HISTORY QUESTIONNAIRE

Dear Sir/Madam,

We kindly ask you to answer the following questions in order to collect important information in order to complete your clinical profile to proceed with the IEO Second Opinion.

MEDICATION

Please, list in detail all medications taken regularly at home (also indicate sleeping pills, sedatives, laxatives, aspirin, contraceptive pills, herbs, homeopathic remedies):

Medication Name	Dose	Mornings	Afternoons	Evenings

Allergies to medications YES □ NO □

If yes, to what medications_____

_____

What medications do you take instead? _____

ILLNESSES

Did/do you suffer from one of the following illnesses? *(underline which ones)*

□ Cardiovascular diseases - *Stroke, Angina, Heart failure, Arrhythmias, Pericarditis, Varicose Veins, Thrombosis, Arterial diseases*

□ Arterial hypertension *(high pressure)*

Do you have a pacemaker, undergo home oxygen therapy or dialysis? **YES** □ **NO** □

Did you have any cardiology check-ups in the last year, such as:

□ Visits and ECG □ Echocardiogram □ Stress Test □ Holter Electrocardiogram 24 h □ Cardiology Check-up in an Emergency Room

For what reason or symptom? _____

PREVIOUS SURGERY/CHEMOTHERAPY/RADIOTHERAPY

Have you had previous surgeries?

1. _____ year _____ 2. _____ year _____

3. _____ year _____ 4. _____ year _____

Have you had previous chemotherapies?

1. _____ year _____ 2. _____ year _____

3. _____ year _____ 4. _____ year _____

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Have you had previous radiotherapy treatments?

1. _____ year _____ 2. _____ year _____

3. _____ year _____ 4. _____ year _____

LIFESTYLE:

Profession _____

Do you drink alcohol? **YES** □ **NO** □ Specify the type and daily consumption _____

Do you smoke or have you smoked? **YES** □ **NO** □ Number of cigarettes a day _____ Stopped from: _____

Usual weigh: Kg _____ Height: cm _____

Have you lost any weight lately? **YES** □ **NO** □

ONLY FOR WOMEN:

Are you pregnant or is a pregnancy possible? **YES** □ **NO** □

Age at first menstrual cycle: _____ Date of last menstrual cycle: _____

Age at beginning of menopause: _____ Hormone replacement therapy **YES** □ **NO** □

Age at first pregnancy: _____ Number of full term deliveries: _____

Breastfeeding: **YES** □ **NO** □

FAMILIARITY: Please provide information on possible diseases affecting relatives

	Alive	Age	Pathology
Father	Yes No		
Mother	Yes No		
Brother	Yes No		
Brother	Yes No		
Sister	Yes No		
Sister	**Yes No**		

REQUIRED CLINICAL DOCUMENTATION To complete the present form it is necessary to attach the clinical documentation listed below. All the documents must be in ENGLISH or ITALIAN.

- Surgery Reports
- Diagnostic Test Results (CT Scan, MRI, RX, ultrasounds,…)
- Completed Lab Studies
- Radiology films/CDs and Written Reports
- Histological Reports

Date_____

Patient or Legal Representative's Signature_____

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