RADIATION ONCOLOGY HEALTHCARE
Patient History Form

Date: ……

……
LAST NAME FIRST NAME

DOB …….... Age .....

Home ☎ …… **Cell** ☎ ……

Reason for the visit: ……

Primary MD: …… Medical Oncologist: .....

Surgeons:……

Other Physicians: ……

Social history: ☐ married ☐ widowed ☐ divorced ☐ single ☐ live alone ☐ assisted living facility_____

Occupation: _____ retired: ☐

Tobacco use: ☐ yes ☐ no number of years _____ amount per day _____ quit (when)_____

Alcohol: ☐ yes ☐ no number of years _____ amount per day _____

Drug use: ☐ yes ☐ no what drugs ?_____ amt._____ frequency_____

Family history of cancer: .....

……

Medical Problems (High Blood Pressure, Diabetes, etc.) ☐ **None**

……

……

……

Surgical Procedures (type and year) ☐ **None**

……

……

……

- **Have you been diagnosed with?** ☐ **Lupus** ☐ **Scleroderma** ☐ **Rheumatoid Arthritis** ☐ **Colitis**
- **Did you ever have radiation therapy or radioactive iodine therapy?** ☐ **Yes** ☐ **No**
- **Do you have?:** ☐ **Pacemaker** ☐ **Chemotherapy Port**

Cancer screening: (month / year)

Colonoscopy……..... Mammogram……..…..…… PAP smear…….

Current Medications and Supplements (name and dose)**:** ☐**None** ***If not enough space bring the list !!!***

……

……

……

……

.....

Allergies to medications / intravenous contrast / others:

……

REVIEW OF SYSTEMS

1. Constitutional ☐ **NORMAL**

Approx. weight 6 months ago _____lb

☐ poor appetite ☐ weight loss ☐ chills ☐ fever ☐ night sweats

2. Ear Nose Throat ☐ **NORMAL**

☐ hearing problem ☐ ear ache ☐ ringing in the ears ☐ sore throat
☐ nose bleed ☐ mouth sores ☐ hoarseness ☐ dentures

3. Eyes ☐ **NORMAL**

☐ glasses ☐ double vision ☐ blurred vision

4. Gastrointestinal ☐ **NORMAL**

☐ heartburn ☐ pain on swallowing ☐ difficulty in swallowing ☐ vomiting blood
☐ nausea ☐ abdominal pain ☐ blood in the stool ☐ diarrhea
☐ constipation ☐ black stools ☐ feeding tube ☐ colostomy

5. Cardiovascular ☐ **NORMAL**

☐ chest pain ☐ palpitations ☐ leg swelling ☐ varicose veins ☐ syncope

6. Respiratory ☐ **NORMAL**

☐ shortness of breath ☐ cough ☐ blood in the phlegm ☐ oxygen use

7. Genitourinary ☐ **NORMAL**

☐ getting up at night to void -- how many times _____ x ☐ pain on urination
☐ blood in urine ☐ urine incontinence ☐ incomplete emptying ☐ decrease in flow
☐ vaginal discharge / spotting ☐ potency problems ☐ testicular lumps

8. Musculoskeletal ☐ **NORMAL**

☐ joint pain ☐osteoporosis ☐ back pain ☐ walking aids

9. Skin / Breast ☐ **NORMAL**

☐ rash ☐ pressure sores ☐ wounds / drains ☐ moles
☐ breast lumps ☐ discharge from the breast ☐ arm swelling

10. Neurological ☐ **NORMAL**

☐ headaches ☐ pins and needles sensation ☐ problems with balance ☐ extremity weakness
☐ speech problems ☐ numbness ☐ sleep problems ☐ seizure

11. Psychiatric ☐ **NORMAL**

☐ memory loss ☐ anxiety ☐depression ☐ suicidal ☐mental illness

12. Endocrine ☐ **NORMAL**

☐ steroid use ☐ heat or cold intolerance ☐ frequent urination ☐ excessive thirst

13. Hematologic / Lymphatic ☐ **NORMAL**

☐ anemia ☐ easy bruising ☐ bleeding ☐ h/o transfusions ☐ swollen glands

14. Allergy / Immunology ☐ **NORMAL**

☐ seasonal allergies ☐ hay fever ☐ food allergies_____

Gynecological history:

First menstruation (age) _____ Last menstruation (month / year or age) _____

Pregnancy (how many) _____ Live births _____ Miscarriage/ Abortion _____

Age @ 1st pregnancy _____

Birth Control Meds (when / how long) _____

Hormone Replacement Therapy (when / how long) _____

Notes: