Patient Name: **MRN#**
Date of Birth:

Past Medical History: Please list previous medical problems such as heart disease, diabetes, stroke, high blood pressure, asthma, bronchitis, emphysema, etc.

_____

_____

_____

Past Surgical History: Pleas list previous surgeries with dates.

_____

_____

_____

Personal/Social History:

Alcohol: Yes No If yes, how many per day _____ or week _____

Tobacco: Yes No If yes, how much per day _____ or week _____

How many years have you smoked? _____

If you quit smoking, when did you quit? _____

Occupation: _____

Family History of Cancer: Who / What type of cancer / Age at diagnosis?

Example: (mother / breast cancer / age 60)

_____

_____

_____

Do you have a pacemaker/defibrillator? Yes No

Have you ever had radiation therapy or cobalt therapy in the past? Yes No

If yes, when in the past? _____

Patient Name: **MRN#**
Date of Birth:

Have you ever had chemotherapy? Yes No

If yes, which drugs? _____

Do you have an autoimmune disease (Rheumatoid, Lupus, etc)? Yes No

Do you have any infectious disease (Tuberculosis, HIV, Hepatitis, etc)? Yes No

Have you ever had x-ray treatment to your neck, thyroid, or tonsils? Yes No

If yes, which one? _____ When? _____

PAIN SCORE:

On a scale of 0 – 10 (0= no pain, 10 = severe, worst pain ever), what is your pain today?

Circle one:

None		Mild		Moderate			Severe		Worst Ever	
0	1	2	3	4	5	6	7	8	9	10

Allergies: Please list all medical allergies

_____

_____

_____

Are you allergic to IV Contrast Dye? Yes No

Medications: Please list all medications you are currently taking or attach a separate list

_____

_____

Preferred Pharmacy _____ Location _____

Patient Name: **MRN#**
Date of Birth:

Females Patients Only

Pregnancy Screening

******It is very important for your radiation physician to be aware if you are or if there is a possibility you could be pregnant before or during your radiation therapy.***

For all females of reproductive age (post menarche to menopause e.g. ages 12-55)

What was the first day of your last complete menstrual period?

Month _____ Day _____ Year _____

Do you currently practice any form of birth control?

Yes _____ No _____

I have / **have not** (circle one) had surgery that will prevent pregnancy.

If surgery: Type _____ Date_____

I understand that women who are pregnant should be counseled regarding risks to the fetus/baby from exposure to radiation and those women of childbearing potential should have a pregnancy test before commencing radiation treatments if there is any chance that you may be pregnant.

To the best of your knowledge, are you pregnant (or is there any chance you could be)?

Yes _____ No _____ Possibly _____

Patient/Guardian Signature _____ Date: _____

For office use only:
Pregnancy Test required (per department guideline)? Yes _____ No _____
If yes:
Consent to test from: _____ Patient _____Guardian
Date test performed: _____
Type of Test: _____
Results: _____ Negative _____ Positive

Patient Name: **MRN#**
Date of Birth:

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

General		
Good General Health Lately	☐No	☐Yes
Recent Weight Change	☐No	☐Yes
Fever	☐No	☐Yes
Fatigue	☐No	☐Yes
Eyes and Vision		
Eye Disease or Injury	☐No	☐Yes
Wear Glasses or Contact Lenses	☐No	☐Yes
Blurred or Double Vision	☐No	☐Yes
Glaucoma	☐No	☐Yes
Ears, Nose, Throat		
Hearing Loss	☐No	☐Yes
Ringing In the Ears	☐No	☐Yes
Earaches or Drainage	☐No	☐Yes
Sinus Problems	☐No	☐Yes
Nose Bleeds	☐No	☐Yes
Mouth Sores	☐No	☐Yes
Bleeding Gums	☐No	☐Yes
Bad Breath or Bad Taste	☐No	☐Yes
Sore Throat or Voice Change	☐No	☐Yes
Swollen Glands in Neck	☐No	☐Yes
Heart and Cardiovascular		
Heart Trouble	☐No	☐Yes
Chest Pains	☐No	☐Yes
Sudden Heartbeat Changes	☐No	☐Yes
Swelling of Feet, Ankles, Hands	☐No	☐Yes
Respiratory		
Frequent Coughing	☐No	☐Yes
Spitting Up Blood	☐No	☐Yes
Shortness of Breath	☐No	☐Yes
Asthma or Wheezing	☐No	☐Yes
Gastrointestinal		
Loss of Appetite	☐No	☐Yes
Change in Bowel Movements	☐No	☐Yes
Nausea or Vomiting	☐No	☐Yes
Frequent Diarrhea	☐No	☐Yes
Painful Bowel Movement/Constipation	☐No	☐Yes
Blood In Stool	☐No	☐Yes
Stomach Pain	☐No	☐Yes
Hematologic/Lymphatic		
Slow To Heal After Cuts	☐No	☐Yes
Easily Bruise or Bleed	☐No	☐Yes
Anemia	☐No	☐Yes
Phlebitis	☐No	☐Yes
Transfusion	☐No	☐Yes
Swollen Glands	☐No	☐Yes

Musculoskeletal		
Joint Pain	☐No	☐Yes
Joint Stiffness or Swelling	☐No	☐Yes
Weakness of Muscles/Joints	☐No	☐Yes
Muscle Pain or Cramps	☐No	☐Yes
Back Pain	☐No	☐Yes
Cold Extremities	☐No	☐Yes
Difficulty in Walking	☐No	☐Yes
Skin and Breasts		
Rash or Itching	☐No	☐Yes
Change in Skin Color	☐No	☐Yes
Change In Hair or Nails	☐No	☐Yes
Varicose Veins	☐No	☐Yes
Breast Pain	☐No	☐Yes
Breast Lump	☐No	☐Yes
Breast Discharge	☐No	☐Yes
Neurological		
Frequent or Recurrent Headaches	☐No	☐Yes
Light Headed Dizzy	☐No	☐Yes
Convulsions or Seizures	☐No	☐Yes
Numbness or Tingling Sensations	☐No	☐Yes
Tremors	☐No	☐Yes
Paralysis	☐No	☐Yes
Stroke	☐No	☐Yes
Head Injury	☐No	☐Yes
Psychiatric		
Memory Loss or Confusion	☐No	☐Yes
Nervousness	☐No	☐Yes
Depression	☐No	☐Yes
Sleep Problems	☐No	☐Yes
Endocrine		
Glandular or Hormone Problem	☐No	☐Yes
Thyroid Disease	☐No	☐Yes
Diabetes	☐No	☐Yes
Excessive Thirst or Urination	☐No	☐Yes
Heat or Cold Intolerance	☐No	☐Yes
Dry Skin	☐No	☐Yes
Change in Hat or Glove Size	☐No	☐Yes
Genitourinary		
Frequent Urination	☐No	☐Yes
Burning or Painful Urination	☐No	☐Yes
Blood in Urine	☐No	☐Yes
Change in Force or Strain W/Urination	☐No	☐Yes
Incontinence or Dribbling	☐No	☐Yes
Kidney Stones	☐No	☐Yes
Sexual Difficulty	☐No	☐Yes
Painful or Irregular Periods	☐No	☐Yes
Vaginal Discharge	☐No	☐Yes