RADIATION ONCOLOGY NEW PATIENT QUESTIONNAIRE

Name _____ Date_____ MD Review_____Time____
MD initial/Date/TIme reviewed

What brings you to Radiation Oncology Clinic today?_____

YOUR HISTORY:

Please list all past surgeries: _____
_____

Please list previous Chemotherapy: _____
_____

Please list previous Radiation Therapy Treatment, if any: _____
_____
_____

Please list all medical illnesses: _____
_____
_____

Please list all drug allergies/ Reactions: _____
_____
_____

What kind of work do you do? _____

Who is your support system? _____

Have you ever smoked? Yes No How many packs per day:_____
How many years have you smoked? _____
Do you still smoke? Yes No If no, when did you quit? _____
Do you drink alcohol Yes No How many drinks a day? _____
Did you drink in the past? Yes No How much? _____

Any history of cancer in your family? _____
Mother's age/medical issues: _____
Father's age/medical issues: _____
Sister(s)' age(s)/issues: _____
Brother(s)' age(s)/issues: _____
Children(s)' age(s)/issues: _____

Have you ever received a pneumonia vaccine? Y N
If yes, when did you receive it? Date: _____
If no, choose one of the following reasons why:
___Not indicated
___Contraindicated (A condition or factor that prevents you from receiving the vaccine)
___Other Medical Reason

Have you ever received a Flu vaccine? Y N
If yes, when did you receive it? Date: _____
If no, choose one of the following reasons why:
___Not indicated
___Contraindicated (A condition or factor that prevents you from receiving the vaccine)
___Other Medical Reason

In the past 3-6 months, have you experienced any of the following?

Fevers	Yes	No	Double Vision	Yes	No
Chills	Yes	No	Change in Vision	Yes	No
Night w\sweats	Yes	No	* * * * *		
Weight loss	Yes	No	Change in hearing	Yes	No
			Pain in the ears	Yes	No
			Pain swallowing	Yes	No
			Hoarseness	Yes	No
High blood pressure	Yes	No	Dentures	Yes	No
Chest pain	Yes	No	Dental problems	Yes	No
Heart attack	Yes	No	Dental cleaning	Yes	No
Peripheral vascular			* * * * *		
Disease	Yes	No	Diarrhea	Yes	No
Swelling in legs/feet/arms	Yes	No	Constipation	Yes	No
Difficulty breathing while			Inflammatory bowel disease, Crohns		
Lying down	Yes	No	or ulcerative colitis	Yes	No
* * * * *			Nausea	Yes	No
Shortness of breath	Yes	No	Vomiting blood	Yes	No
Shortness of breath			Change in stool	Yes	No
W/activity	Yes	No	Loss of appetite	Yes	No
Cough	Yes	No	Pain with urination	Yes	No
Bloody sputum	Yes	No	Frequent urination	Yes	No
Asthma	Yes	No	Blood in the urine	Yes	No
History of tuberculosis	Yes	No	Pelvic discomfort	Yes	No
Pneumonia	Yes	No	Lesions on external		
History of chronic obstructive			genitalia	Yes	No
Pulmonary disease			* * * * *		
(COPD)	Yes	No	Joint pain/ache	Yes	No
Emphysema	Yes	No	Arthritis	Yes	No
* * * * *			Severe pain	Yes	No
Rashes	Yes	No	* * * * *		
Itchy Skin	Yes	No	Headaches	Yes	No
Any history of collagen			Loss of limb function	Yes	No
Vascular disease			Numbness	Yes	No
(Lupus, Sjorgrens)	Yes	No	Seizures	Yes	No
Any history of skin cancer	Yes	No	Memory loss	Yes	No
* * * * *			Loss of balance	Yes	No
Medications for emotional			Loss of consciousness	Yes	No
Disorder	Yes	No	Any history of strokes	Yes	No
Depression	Yes	No	Other nerve problems	Yes	No
Any history of psychiatric			* * * * *		
Disorder	Yes	No	Anemia	Yes	No
* * * * *			Easy bleeding	Yes	No
Thyroid dysfunction	Yes	No	* * * * *		
Pituitary dysfunction	Yes	No	Natural Medicine	Yes	No
Diabetes	Yes	No	Acupuncture	Yes	No

GYNECOLOGY (females only)

Name_____ **Date** _____

Description

Vaginal discharge	Yes	No	_____
Excessive vaginal bleeding	Yes	No	_____
Age menstruation started			_____
How often do you menstruate?			_____
When was your last menstrual period?			_____
How many days do you flow?			_____
Age of menopause:			_____
Number of pregnancies			_____
Age at first full-term pregnancy			_____
Number of live births			_____
Number of multiple births (twins, etc)			_____
Number of abortions			_____
Number of miscarriages			_____
History of birth control pills	Yes	No	What years? _____
History of hormone/estrogen	Yes	No	What years? _____
Did you breastfeed your children?		Yes No	_____
Are you pregnant today?		Yes No	_____
Are you planning to become pregnant?		Yes No	_____
Have you ever had breast surgery?		Yes No	_____
Any family history of breast cancer?		Yes No	_____
When was your last pelvic exam?			_____
Did you have a normal Pap smear?			_____

CARDIAC DEVICE QUESTIONS

Do you have an implanted cardiac device? Yes No

If yes, who is your cardiologist? _____

If yes, is it a defibrillator or pacemaker? (Please circle answer)

If you have a pacemaker, are you "pacemaker-dependent" (ie- your heart will not beat at all without the pacemaker)? Yes No

If you have a pacemaker or defibrillator, please give the ID card to the receptionist to make a copy of the card.

OTHER IMPLANTED DEVICES

Do you have any other implanted devices that we should know about? Yes No
Examples: spinal cord stimulator implant, cochlear implants, portacath, programmable shunt, etc….

Please list type of device:

_____