Department of Radiation Oncology

Patient's Health History

PATIENT PROFILE

Name ________________________ Date ____________________

Age __________ Current Weight _________ Usual Weight _________ Height __________

Living Will [ ] Yes [ ] No Karnofsky Score ______ Allergies ____________________

Blood Pressure ___________ Pulse ________ Respiration _________ Temperature _________

Do you have Advanced Directives? No ☐ Yes ☐
Are you claustrophobic? No ☐ Yes ☐

Do you have difficulty laying flat for an hour? No ☐ Yes ☐

DIAGNOSIS:

Presenting problem and patient's own history of problem:

____

____

____

PAST HISTORY

1. PAST MEDICAL ILLNESS (Do you have or have you ever had any of the following)

	No	Yes
1. Diabetes	☐	☐
2. Asthma	☐	☐
3. Emphysema/COPD	☐	☐
4. High blood pressure	☐	☐
5. High cholesterol	☐	☐
6. Ulcers	☐	☐
7. Heart disease/attack	☐	☐
8. Pacemaker	☐	☐
9. Seizures	☐	☐
10. Thyroid disease	☐	☐
11. Tuberculosis	☐	☐
12. Rheumatoid arthritis	☐	☐
13. Systemic lupus erythematosis	☐	☐
14. Stroke	☐	☐
15. Depression/psychological illness	☐	☐
16. Latex allergy	☐	☐
17. Hip Replacement	☐	☐
18. Other ____________________		

2. PAST SURGERY (Indicate type of surgery and year)

1. ____
2. ____
3. ____
4. ____
5. ____

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3. PAST INJURIES (Indicate type and year)
   1. ______________________________
   2. ______________________________
   3. ______________________________

4. Have you ever felt threatened by anyone? No ☐ Yes ☐
5. Have you ever been abused in any way? No ☐ Yes ☐
6. Have you ever had radiation treatments? No ☐ Yes ☐
   If yes, where and when? ______________________________
7. Have you ever had chemotherapy? No ☐ Yes ☐
   If yes, where, when and what kind? ______________________________

PRESENT MEDICATIONS (Please list)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Are you allergic to any medications? No ☐ Yes ☐

If yes, please list ______________________________

____

PAIN

Do you have pain? No ☐ Yes ☐

Where is the pain? ______________________________

How long does the pain last? ______________________________

Does the pain prevent you from doing normal activities? No ☐ Yes ☐

Are you taking any medication for pain? No ☐ Yes ☐

If yes, what? ______________________________

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FAMILY HISTORY

	Alive	Deceased	Cause of Death	Age
Mother	_____	_______	_________________________	_____
Father	_____	_______	_________________________	_____
Siblings	_____	_______	_________________________	_____
	_____	_______	_________________________	_____
Children	_____	_______	_________________________	_____
	_____	_______	_________________________	_____
	_____	_______	_________________________	_____
	_____	_______	_________________________	_____

Is there a history of cancer in your family? No ☐ Yes ☐

If yes, please list:

	Relative	Type of Cancer	Alive	Deceased	Age
1.	_______________	____________________	________	________	_____
2.	_______________	____________________	________	________	_____
3.	_______________	____________________	________	________	_____
4.	_______________	____________________	________	________	_____

SOCIAL HISTORY

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Occupation ____

Level of Education: some high school ☐ high school ☐ 2-year college ☐
4-year college ☐ graduate school ☐

Do you drink alcoholic beverages? No ☐ Yes ☐

If yes, how much? Social ☐ moderate (1-2 drinks/day) ☐ Heavy (3 or more/day) ☐

Do you smoke or use smokeless tobacco now? No ☐ Yes ☐

If yes, how much? ___________ Packs per day for _______years

Did you smoke in the past? No ☐ Yes ☐

If yes, how much? ______________ Pack per day for __________years

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Have you ever been exposed to occupational hazards? (Lead, asbestos, chemical solvents, etc.)

No ☐ Yes ☐ ____________________

Have you ever been exposed to environmental hazards? (Radon, toxic wastes, second-hand smoke, pollution, etc.) No ☐ Yes ☐

If yes, what and when? ____________________

REVIEW OF SYSTEMS

Do you have any of the following?	No	Yes
Constitutional/General		
1. Notable weight loss or gain	☐	☐
2. Loss of appetite	☐	☐
3. Fatigue	☐	☐
4. Trouble sleeping	☐	☐
Eyes/Ears/Nose/Throat/Mouth		
5. Hearing problems	☐	☐
6. Ringing in ears	☐	☐
7. Hoarseness	☐	☐
8. Difficulty or pain swallowing	☐	☐
9. Gums Bleeding	☐	☐
10. Blurry or double vision	☐	☐

Respiratory/Pulmonary	No	Yes
11. Chronic cough	☐	☐
12. Blood in sputum	☐	☐
13. Shortness of breath	☐	☐
14. Asthma or wheezing	☐	☐
15. Tuberculosis	☐	☐
Cardiovascular		
16. Chest pain or palpitations	☐	☐
17. Heart murmur	☐	☐
18. Hypertension	☐	☐
19. Stroke	☐	☐
20. Leg or ankle swelling	☐	☐

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Gastrointestinal

21. Nausea or vomiting	☐	☐
22. Abdominal pain	☐	☐
23. Diarrhea	☐	☐
24. Constipation	☐	☐
25. Hemorrhoids	☐	☐
26. Rectal bleeding	☐	☐
27. Ulcers	☐	☐
28. Change in bowel habits	☐	☐

Genitourinary

29. Increased urinary frequency	☐	☐
30. Pain with urination	☐	☐
31. Blood in urine	☐	☐
32. Impotence	☐	☐
33. Decreased interest in sex	☐	☐

Musculoskeletal

34. Joint swelling	☐	☐
35. Arthritis	☐	☐
36. Cramps	☐	☐
37. Arm or leg weakness	☐	☐
38. Numbness	☐	☐
39. Difficulty with balance	☐	☐
40. Bone pain	☐	☐

Skin/Breast	**No**	**Yes**
41. Rash	☐	☐
42. Itching	☐	☐
43. Sores	☐	☐
44. Healing Incision	☐	☐

Neurological

45. Seizures	☐	☐
46. Vertigo	☐	☐
47. Headaches	☐	☐
48. Dizziness	☐	☐

Psychiatric/Emotional

49. Depression	☐	☐
50. Anxiety	☐	☐
51. Memory Loss	☐	☐

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Endocrine

52. Diabetes ☐ ☐
53. Thyroid ☐ ☐

Hematologic/Lymphatic

54. Easy Bruising ☐ ☐
55. Anemia ☐ ☐
56. Leukemia ☐ ☐

Allergic/Immunologic

57. Allergies ☐ ☐
58. Immune system problems ☐ ☐

Other

59. ____

Immunization Record (record the last dose taken)
Tetanus ________________
Pneumonia Vaccine ________________
Flu Vaccine ________________
Hepatitis Vaccine ________________

Reviewed by: ____ Date __________