



**Radiation Oncology  
Patient History**

Patient _____
DOB _____ Age _____

<b>T</b>	<b>P</b>	<b>R</b>	<b>BP</b>	<b>O<sub>2</sub> Sat</b>	<b>Ht</b>	<b>Wt</b>
----------	----------	----------	-----------	--------------------------	-----------	-----------

**Medical illnesses/ diseases**

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Hiatal hernia  | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Lupus     |

Other \_\_\_\_\_

**Surgeries**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Skin cancer   | <input type="checkbox"/> Coronary bypass | <input type="checkbox"/> Appendectomy     | <input type="checkbox"/> Hysterectomy     |
| <input type="checkbox"/> Cataracts     | <input type="checkbox"/> Heart valve     | <input type="checkbox"/> Hernia repair    | <input type="checkbox"/> Hip replacement  |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Breast biopsy   | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Knee replacement |
| <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Gallbladder     | <input type="checkbox"/> Cesarean section | <input type="checkbox"/> Disk surgery     |

Other \_\_\_\_\_

**Previous treatment**

Radiation therapy \_\_\_\_\_

Chemotherapy \_\_\_\_\_

Hormone therapy \_\_\_\_\_

Other (acupuncture, herbs, vitamins) \_\_\_\_\_

**Current medications**

	Drug name	Dose	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			

**Medication allergies** \_\_\_\_\_  None known

**Social history** Occupation \_\_\_\_\_ Marital status \_\_\_\_\_

Habits	Tobacco	<input type="checkbox"/> Never	Alcohol	<input type="checkbox"/> Never
Amount daily				
Total years				

**Family history (check those items which apply):**

	Grandfathers		Grandmothers		Parents		Siblings		Children	
	Paternal	Maternal	Paternal	Maternal	Father	Mother	Brother	Sister	Son	Daught
Cancer										
Other										

**Symptoms (check those items which apply):**

1. General symptoms

- Change in appetite
- Change in weight
- Fatigue
- Fever
- Chills
- Night sweats
- Hot flashes
- Itching

2. Eyes

- Glasses
- Contact lenses
- Cataracts
- Glaucoma
- Macular degeneration
- Change in vision

3. Ears, nose, mouth, throat

- Hearing problems
- Nose bleeds
- Sinus problems
- Dental problems
- Sore throat
- Hoarseness

4. Cardiovascular (Heart and circulation)

- Heart attack
- Chest pain
- Irregular heartbeat
- Difficulty breathing when flat
- Leg or ankle swelling
- Circulatory problems

5. Respiratory (Lungs)

- Shortness of breath
- Wheezing
- Cough
- Sputum or phlegm production
- Coughing up blood

6. Gastrointestinal (Stomach and bowels)

- Swallowing problems
- Heartburn
- Stomach ulcers
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Rectal bleeding
- Hemorrhoids
- Abdominal pain

7. Genitourinary (Kidneys, bladder, genitals)

- Slow stream
- Urgency
- Frequency
- Up at night to urinate \_\_\_\_\_ times
- Burning
- Bleeding
- Leakage
- Urinary tract infections

Men only....

- Prostate infections
- Impotence

Women only....

- Vaginal discharge
- Vaginal bleeding
- Menopause at age \_\_\_\_\_
- Hormones

8. Musculoskeletal (Bones and joints)

- Arthritis: locations \_\_\_\_\_
- Stiffness
- Swelling
- Pain: locations \_\_\_\_\_

9. Neurologic

- Headache
- Balance difficulties
- Loss of consciousness
- Seizures
- Weakness in arms or legs
- Numbness in arms or legs

10. Psychiatric

- Anxiety
- Depression
- Trouble sleeping

11. Endocrine (Glands)

- Hyperthyroidism
- Hypothyroidism
- Diabetes

12. Hematologic (Blood)

- Anemia
- Bleeding
- Lymph nodes

13. Integumentary (Skin or breasts)

- Skin rash
- Skin cancer
- Breast lumps
- Nipple discharge
- Mammography last done \_\_\_\_\_