PATIENT INITIAL HISTORY QUESTIONNAIRE

PENINSULA Radiation Oncology CENTER

Name:	Date of Birth:	Age:

Street:	Please Provide Us With the Names of Your Physicians	
City:	Family Physician	
Preferred Nickname:	Referring Physician	
Day Phone:	Medical Oncologist	
Work Phone:	Other Physician	
Cell Phone:	Other Physician	
Can we leave a message on your voice mail? ❒ Yes ❒ No	Can we call you at work? ❒ Yes ❒ No	

ESCORT INFORMATION

Spouse or Significant Other's name: _____

Who will accompany you on your first visit? _____

Do you wish to have your escort included in your initial meeting with the physician? ❒ Yes ❒ No

If yes, relationship and name: _____

PRIMARY PROBLEM

Please explain the reason you are here today:

_____

_____

OTHER MEDICAL SERVICES

Please check if you have seen any of the following specialists:

❒ Radiation Oncologist ❒ Medical Oncologist ❒ Surgeon ❒ None Apply

LANGUAGE

Is English your primary language? ❒ Yes ❒ No If no, list primary language. _____

Are you comfortable conversing in English? ❒ Yes ❒ Comment _____

EDUCATION

Please check level of education completed.

❒ Grammar School ❒ High School ❒ College Other: _____

PAST CANCER HISTORY

Have you ever had any of the following?

❒ Prior Cancers ❒ Prior Radiation ❒ Prior Chemotherapy ❒ None Apply

Are you taking hormonal therapy? (i.e., Tamoxifen) ❒ No ❒ Yes If yes, what? _____

Patient Name: _____

GENERAL HISTORY

Before my current illness, I would describe my overall health as:

❒ Excellent ❒ Good ❒ Fair ❒ Poor

At the present time I feel:

❒ Excellent ❒ Good ❒ Fair ❒ Poor

PAST SURGERIES *List any surgeries and year performed.* ❒ None

Past Surgery	Year	Where

PAST ILLNESSES or HOSPITALIZATION *List below with year occurred.* ❒ None

Past Illness or Hospitalization	Year	Where

MEDICATIONS *List all current medications and doses and any herbs, supplements or vitamins* ❒ None

Medication/Supplement	How Many Do You Take Daily?	Reason for Taking Medication/Supplement

ALLERGIES *List all allergies and reactions.* ❒ None

Allergy	Reaction
Vaccines Flu	❒ Yes ❒ No Date:
Pneumococcal	❒ Yes ❒ No Date:

Are you pregnant, or still want to have children? ❒ No ❒ Yes: _____

Do you use a method of birth control? ❒ No ❒ Yes: _____

Do you have lupus or scleroderma? ❒ No ❒ Yes: _____

If you have head-or-neck cancer, who is your dentist? _____

Patient Name: _____

MARITAL STATUS

❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Significant Other
❒ Living Together ❒ Available to assist _____

CHILDREN

❒ Children ❒ Alive ❒ Well ❒ Natural ❒ Adopted
# of Children _____ ❒ Lives Locally ❒ Available to assist

PRINCIPAL CARE PERSON

Name of Principal Care Person _____

Do they live with you? ❒ Yes ❒ No Relationship to patient _____

Is this person willing/able to help you? ❒ Yes ❒ No Comment: _____

FAMILY HISTORY

Mother r Alive r Deceased Cause _____ Age _____

Father r Alive r Deceased Cause _____ Age _____

Please list family member(s) in the appropriate box if there is a history of the following diseases(s):

Heart Disease	High Blood Pressure	Stroke	Diabetes

List other hereditary diseases: _____

FAMILY HISTORY of CANCER

Immediate		Type of Cancer	Maternal		Type of Cancer	Paternal		Type of Cancer
Mother	❒ Yes		Grandmother	❒ Yes		Grandmother	❒ Yes	
Father	❒ Yes		Grandfather	❒ Yes		Grandfather	❒ Yes	
Sister	❒ Yes		Aunt	❒ Yes		Aunt	❒ Yes	
Brother	❒ Yes		Uncle	❒ Yes		Uncle	❒ Yes	
Children	❒ Yes							

Has anyone been informed that they have ❒ BRCA1/2, ❒ LYNCH Syndrome, or ❒ other hereditary

❒ Other cancer problems. _____

WORK HISTORY

Occupation _____

Are you still working? ❒ Yes ❒ No

Were you exposed to carcinogenic substances, asbestos? ❒ Yes ❒ No List: _____

Has your illness forced you to stop working? ❒ Yes ❒ No Date: _____

Do you anticipate being off work? ❒ Yes ❒ No Date: _____

Has your illness forced significant other to stop working? ❒ Yes ❒ No Date: _____

Has your illness forced significant other to change hours? ❒ Yes ❒ No Date: _____

Have you applied for disability? ❒ Yes ❒ No Date: _____

Date Disability Started: _____ Date of Application: _____

Patient Name: _____

SOCIO-ECONOMIC

RELIGION (optional): _____

Special Requirements: _____

Potential Problems: _____

Transportation Problems: _____

Financial/Home Care Needs: _____

Any financial concerns staff can help with? _____

Do you have any special concerns, fears or history (such as abuse), or any sexual concerns/issues that would have an effect on your care during treatments that you wish us to know about or that you would like to speak to the physician about?

❒ Yes ❒ No If yes, Please describe:_____

COPING

Has your illness forced a change in your day-to-day activities? ❒ Yes ❒ No

Describe _____

Has your illness forced a move or a change in your living arrangement? ❒ Yes ❒ No

Describe _____

Number living in house_____ Relationship(s) _____

Is support system adequate to fit patient's needs? ❒ Yes ❒ No

Describe _____

PAIN

Do you have pain? ❒ Yes ❒ No

If yes, Where? _____

Please rate your current pain on a scale of 1-10. 1 being best, or no pain. 10 being worst, or intolerable.

0	1	2	3	4	5	6	7	8	9	10

What medication(s) are you taking for pain? _____

Does medication relieve pain? ❒ Yes ❒ No

When does your pain usually occur? _____

Comment: _____

EXERCISE HISTORY

Do you exercise regularly? ❒ Yes ❒ No

Type of exercise/frequency? _____

Comments: _____

Patient Name: _____

HISTORY OF TOBACCO, ALCOHOL and DRUGS

Tobacco

❒ No ❒ Yes Ever use tobacco? How many packs per day? _____

❒ No ❒ Yes Currently use tobacco? What age started? _____

What age stopped? _____

If yes, check type(s):

❒ Cigarettes ❒ Snuff
❒ Pipe ❒ Chew
❒ Cigars ❒ Other _____

To Be Completed By MD:
Total Pack Years: _____ .

Alcohol

❒ No ❒ Yes Do you drink alcohol? If yes, how many drinks per day? _____

Drugs

❒ No ❒ Yes Currently use drugs? If yes, what drugs? _____

CURRENT CESSATION or HELP PROGRAMS

❒ No ❒ Yes Are you currently participating in any support or self-improvement programs?

If yes, ❒ Smoke Cessation Program ❒ AA ❒ NA Other _____

Would you like to participate in a smoking cessation program? _____

CURRENT WELLNESS PROGRAMS or ALTERNATIVE

❒ No ❒ Yes Are you currently participating in any alternative medicines?

❒ Yoga	❒ Chiropractic	❒ Reiki	❒ Acupuncture	❒ Holistic

PROGRAMS YOU MAY BE INTERESTED IN

❒ No ❒ Yes Would you be interested in any of the following programs or services?

❒ Look Good Feel Better	❒ Cancer Support Group	❒ Transportation Assistance	❒ Oncology Rehab

ADVANCE DIRECTIVE (Living Will)

We are required by the State to inquire.

Do you have an Advance Directive? ❒ Yes ❒ No
If yes, would you provide us with a copy for your medical record? ❒ Yes ❒ No
If you do not have an advance directive, would you like information? ❒ Yes ❒ No

Information for advance directive provided by: _____ *Date:* _____

OTHER

Please include any other information that you think is important that we know.

_____

_____

Patient Name: _____

REVIEW OF SYSTEMS: Please ☐ any of the items that apply to you or that you may be experiencing.

GENERAL
Normal Weight: _____
❒ Recent Weight Loss
Amount: _____
❒ Recent Weight Gain
Amount: _____
❒ Loss of appetite
❒ Fatigue
❒ Weakness
❒ Fevers
❒ Chills
❒ Night Sweats
❒ Sleep Problems

EYES
❒ Glasses
❒ Contact lenses
❒ Glaucoma
❒ Cataracts
❒ Double vision
❒ Change in vision
❒ Other vision problems

EARS/NOSE/THROAT
❒ Loss of hearing
❒ Hearing aid
❒ Ringing in ears
❒ Other ear problems
❒ Nose bleed
❒ Dentures
❒ Dental problems
❒ Frequent sore throats
❒ Hoarseness
❒ Difficulty swallowing
❒ Dry mouth
❒ Loss of taste
❒ Neck stiffness
❒ Neck pain or swelling

CARDIOVASCULAR
❒ Pacemaker
❒ Chest pain
❒ Irregular heartbeat
❒ Palpitations
❒ Hypertension
❒ Sleep sitting or propped up
❒ Short breath when lying down
❒ Fainting spells
❒ Leg pain while walking
❒ Swelling in feet
❒ Varicose veins
❒ Oxygen use at home

RESPIRATORY
❒ Shortness of breath
❒ Difficulty breathing
❒ Coughing
❒ Dry cough
❒ Coughing up sputum
❒ Coughing up blood

GASTROINTESTINAL
❒ Heartburn
❒ Nausea/upset stomach
❒ Abdominal pain
❒ Vomiting
❒ Jaundice
❒ Change in bowel habits
How long?_____
Movements per Day _____
❒ Constipation
❒ Diarrhea
❒ Blood in stool
❒ Hemorrhoids/fissures

GENITOURINARY
❒ Difficulty urinating
❒ Frequent urination
❒ Painful urination
❒ Up at night to pass urine
How Many Times _____
❒ Blood in urine
❒ Color change of urine
❒ Sexual difficulties

WOMEN ONLY
_____ Age at menarche
❒ Menopause (Age) _____
Date of last menstrual
Period:_____
_____ # of pregnancies
_____ age of first pregnancy

_____ # of live births
❒ Hot flashes _____
❒ Hormone therapy
_____ contraceptive use

MEN ONLY
❒ Impotence
❒ Difficulty with erections
❒ Penile Discharge
❒ Testicular mass
❒ Testicular pain

MUSCULOSKELETAL
❒ Leg cramps
❒ Painful muscles
❒ Painful joints
❒ Artificial joints
❒ Prosthesis
❒ Physical disabilities
❒ Gout

SKIN & BREAST
❒ Itching ❒ Blotchy
❒ Rash ❒ Scaling
❒ Sores ❒ Growths
❒ Pain in breast
❒ Color changes
❒ Lump or mass in breast or armpit
❒ Discharge or bleeding from nipple
❒ Change in nipple
❒ Nipple inversion
❒ Change in size, shape or contour

NEUROLOGICAL
❒ Headaches
❒ Tremors
❒ Memory Loss
❒ Difficulty finding words
❒ Difficulty writing
❒ Difficulty thinking clearly
❒ Numbness or tingling
❒ Dizziness
❒ Loss of consciousness
❒ Seizures
❒ Coordination
❒ Unsteady gait

PSYCHIATRIC
❒ Nervousness
❒ Anxiety
❒ Depression
❒ Change in personality
❒ Relationship problems

ENDOCRINE
❒ Excessive thirst
❒ Excessive urination
❒ Thyroid problems

HEMATOLOGIC & LYMPHATIC
❒ Swollen lymph glands
❒ Excessive bruising
❒ Excessive bleeding

I verify the above information is true and correct to the best of my belief.

Patient Signature _____ Date: _____

Reviewed by _____ Date: _____

Reviewed by Physician _____ Date: _____