OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

RADIATION ONCOLOGY — NEW PATIENT

PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

REFERRING PHYSICIAN

Name: _____ City: _____ Phone: _____

List your recent physicians: _____

_____

Why are we seeing you today? _____

Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

List any hospitalizations, surgeries and consultations

	DATE	DOCTOR	REASON	HOSPITAL/FACILITIES
1.				
2.				
3.				

Are you allergic to any medications, foods, IV contrast, x-ray dye or latex?

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Are you diabetic? ☐ No ☐ Yes Do you have any metal implants? ☐ No ☐ Yes

Are you claustrophobic? ☐ No ☐ Yes

HEALTH REVIEW

Have you experienced any of the following within the last month? (Please check all that apply)

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Failing Vision
- ☐ Eye Pain
- ☐ Nasal Problems
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Chewing Problems
- ☐ Trouble Swallowing
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Persistent Cough
- ☐ Dry Cough
- ☐ Cough Up Phlegm
- ☐ Cough Up Blood
- ☐ Bloody Urine
- ☐ Infection
- ☐ Change in Weight
- ☐ Loss of Appetite
- ☐ Stomach Pain
- ☐ Nausea/Vomiting
- ☐ Vomiting Blood
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Incontinence
- ☐ Voiding Too Often
- ☐ Urinary Discharge
- ☐ Painful Voiding
- ☐ Trouble Sleeping
- ☐ Tired
- ☐ Weak
- ☐ Nervousness
- ☐ Depression
- ☐ Sexual Problems
- ☐ Skin Rash
- ☐ Joint Pain
- ☐ Numbness
- ☐ Arm or Leg Weakness
- ☐ Trouble with Balance
- ☐ History of Falls
- ☐ Lumps/Masses
- ☐ Tremors
- ☐ Seizures
- ☐ Night Sweats

Please list your current medications

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

Drug: _____ Dose (mg): _____ Frequency: _____

HEALTH HISTORY

Have you ever had any of the following? (Please check all that apply)

- ☐ Heart Problems
- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Blood Clot
- ☐ Liver Disorder
- ☐ Hepatitis
- ☐ Yellow Jaundice
- ☐ Kidney Condition
- ☐ Bladder Infection
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Goiter
- ☐ Colitis
- ☐ Blood in Bowels
- ☐ Glaucoma
- ☐ Prostate Trouble
- ☐ TB
- ☐ Paralysis
- ☐ Arthritis
- ☐ Gout
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Gallbladder Disease
- ☐ Meningitis
- ☐ Convulsions

FOR WOMEN ONLY

At what age did you have your **first** period? _____

At what age did you have your **last** period? _____

Are you pregnant? ☐ Yes ☐ No

How many times have you been pregnant? _____

How many live births? _____

How old were you when your first child was born? _____

Did you ever take birth control pills? ☐ Yes ☐ No

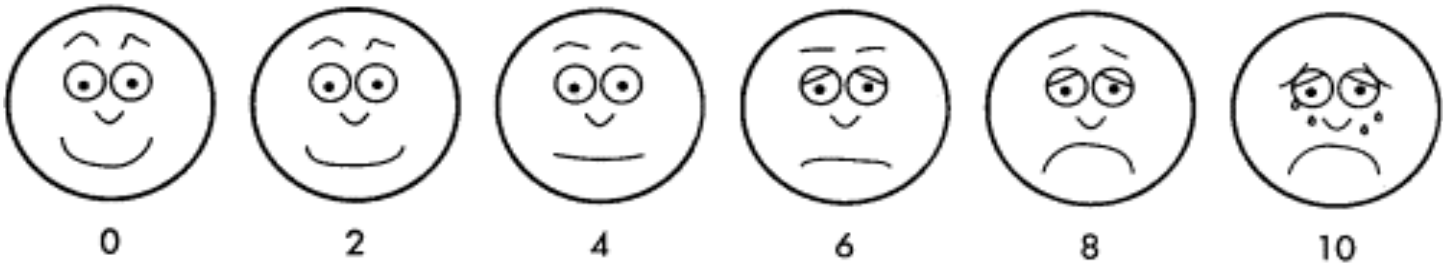
When and for how long? _____

Did you breast feed? ☐ Yes ☐ No

When was your last mammogram? _____

PAIN ASSESSMENT

Pain Scale: Face Rating



0	2	4	6	8	10
No Pain	Mild Pain	Discomforting	Distressing	Intense	Excruciating

Using the pain scale above, what is an acceptable level of pain for you? _____

Have you been having pain in the **last month?** ☐ Yes ☐ No

Location of pain: _____

Describe your pain: _____

What are you doing/taking to control your pain? _____

Using the pain scale above, rate your pain: _____

Location of pain: _____

Describe your pain: _____

Have you ever experienced pain in the past? ☐ Yes ☐ No

Location: _____

Describe your pain: _____

Using the pain scale above, rate that pain: _____

What did you do/take to control that pain? _____

FAMILY HEALTH HISTORY

PARENTS

If living | If deceased

Name	Age	Health problems	If deceased, age & cause of death
Father:			
Mother:			

SIBLINGS

If living | If deceased

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

SPOUSE

If living | If deceased

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			

CHILDREN

If living | If deceased

Name	Sex	Age	Health problems	If deceased, age & cause of death
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

SOCIAL STATUS

Living Situation: ☐ Home ☐ Nursing Home ☐ Apartment ☐ Assisted Living ☐ Other

If you checked nursing home or assisted living above, give the name of the facilities: _____

_____

Living Arrangement: ☐ Alone ☐ With Spouse/Partner ☐ Other

Primary Care Giver: ☐ Self ☐ Spouse ☐ Child ☐ Relative ☐ Friend ☐ Paid Attendant ☐ Other

Is there anyone who can help with your care at home if needed? ☐ Yes ☐ No

Are others dependent on you? ☐ Yes ☐ No

Pharmacy Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PHYSICIANS INVOLVED IN YOUR CARE

Referring Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specialist Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specialist Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of person completing form: _____ Date/Time: _____