Northeastern Oklahoma CANCER INSTITUTE

Radiation Oncology Patient Information

DATE:

NAME:		**REFERRING PHYSICIANS:**
MRN:		
DOB:		
Gender:		
MD:		

Problem/Reason for visit:
Phone:
Address:
Occupation/Year of Retirement:

Emergency Contacts:

Name		**Relationship**		**Phone**	
Name		**Relationship**		**Phone**	

Please answer the following questions to the best of your ability. If you have a problem completing any section, please ask the doctor for an explanation.

Have you been diagnosed with any chronic illness (e.g., diabetes, high blood pressure, etc.)?

Have you been admitted to a hospital (other than for surgery and/or childbirth)?
If yes, for what?

Have you had any of the following surgeries? (Check yes or no)

Surgery	Yes	No	Surgery	Yes	No
Tonsillectomy	☐	☐	Breast Biopsy	☐	☐
Appendectomy	☐	☐	Mastectomy	☐	☐
Hysterectomy	☐	☐	Colon/Rectal Surgery	☐	☐
Gallbladder	☐	☐	Prostate	☐	☐
Bronchoscope	☐	☐	Hemorrhoidectomy	☐	☐
ung Surgery	☐	☐			

List any other surgeries not mentioned above:
Have you ever had any complications with anesthesia in the past?
If yes, please list:

Do you have any allergies to drugs, food, or environment (e.g., dust)?
If yes, please list:

Are you presently taking any medications?
If so, please list the name of each drug, the dosage, and how many times a day you take it:

DRUG	DOSAGE	HOW MANY TIMES A DAY

Have you ever smoked?
If yes, number of packs per day?
How many years?

Do you consume alcohol?
How much? **How Long?** **Hard Liquor?** **Beer?**

Has any blood relative ever had any type of malignancy (cancer)? **If so, who?**
Cancer, including leukemia? **Who?**

Have you ever experienced any of the following?

SKIN	Yes	No
Skin cancer	☐	☐
List any other abnormalities:		

HEAD	Yes	No	EARS	Yes	No	NOSE	Yes	No
Headaches	☐	☐	Hearing difficulty	☐	☐	Nose bleeds	☐	☐
Migraines	☐	☐	Buzzing/Ringing in ears	☐	☐	Sinusitis	☐	☐
Fainting spells	☐	☐	Deafness	☐	☐	Post nasal drip	☐	☐
Tension	☐	☐	Drainage from ear(s)	☐	☐			
Dizziness	☐	☐						

INITIAL:	

EYES	Yes	No	EYES	Yes	No
Poor vision corrected by glasses	☐	☐	Double vision	☐	☐
Glaucoma	☐	☐	Night blindness	☐	☐
Cataracts	☐	☐	Pain in eyes	☐	☐

HEART	Yes	No	HEART	Yes	No
Heart murmur	☐	☐	Heart attack	☐	☐
Rheumatic fever	☐	☐	Anemia	☐	☐
Chest pain	☐	☐	Shortness of breath when lying flat	☐	☐
Pressure attacks	☐	☐	Swelling of feet or ankles	☐	☐
Pain or cramps in legs when walking	☐	☐	Blood transfusions	☐	☐
High blood pressure	☐	☐	Poor circulation	☐	☐
Heart failure	☐	☐	Fainting spells	☐	☐

LUNG	Yes	No	LUNG	Yes	No
Bronchitis	☐	☐	Emphysema	☐	☐
Tuberculosis	☐	☐	Pleurisy	☐	☐
Pneumonia	☐	☐	Chronic-cough (frequent)	☐	☐
Excessive/colored phlegm	☐	☐	Wheezing	☐	☐

ENDOCRINE	Yes	No	ENDOCRINE	Yes	No
Night-sweat	☐	☐	Thyroid trouble	☐	☐
Change in scalp/body hair	☐	☐	Poor tolerance of heat	☐	☐
Poor tolerance of cold	☐	☐	Enlarged glands (neck, under arms)	☐	☐
Abnormal thirst	☐	☐	Hot flashes	☐	☐

GASTROINTESTINAL	Yes	No	GASTROINTESTINAL	Yes	No
Liver disease	☐	☐	Heart burn (indigestion)	☐	☐
Excess gas	☐	☐	Nausea	☐	☐
Vomiting blood	☐	☐	Diarrhea	☐	☐
Constipation	☐	☐	Any bloody stools	☐	☐
Any black, tarry stools	☐	☐	Any mucous in stools	☐	☐
Hemorrhoids	☐	☐	Gallbladder disease	☐	☐
Yellow jaundice	☐	☐	Change in bowel habits	☐	☐
Weight changes ≥ 10lbs in 6 months	☐	☐	Trouble eating raw, greasy, spicy foods	☐	☐

INITIAL:	

MUSCULOSKELETAL	Yes	No	MUSCULOSKELETAL	Yes	No
Muscle weakness in arm or leg	☐	☐	Painful joints	☐	☐
Swollen joints	☐	☐	Pain/aches in muscles	☐	☐
Gout	☐	☐	Arthritis	☐	☐

NEUROLOGICAL	Yes	No	NEUROLOGICAL	Yes	No
Difficulty with balance/walking	☐	☐	Loss of consciousness	☐	☐
Tremors/shakes	☐	☐	Paralysis	☐	☐
Loss of coordination	☐	☐	Tingling/numbness	☐	☐
Stroke	☐	☐	Speech difficulty	☐	☐

GENITUORINARY	Yes	No	GENITUORINARY	Yes	No
Any kidney infection	☐	☐	Any bladder infections	☐	☐
Pain/burning during urination	☐	☐	Blood in urine	☐	☐
Cloudy urine	☐	☐	Kidney stone	☐	☐
Gonorrhea	☐	☐	Syphilis	☐	☐
Difficulty passing urine	☐	☐	Difficulty controlling urine	☐	☐
Urination during the night	☐	☐			

MEN ONLY	Yes	No	MEN ONLY	Yes	No
Prostate trouble	☐	☐	Discharge from penis	☐	☐
Change in size of testicle	☐	☐	Testicular pain	☐	☐
Difficulty having erections	☐	☐	Breast lump	☐	☐

WOMEN ONLY		WOMEN ONLY	Yes	No
Age of onset		Regular	☐	☐
Usual duration		Birth control pills	☐	☐
Heavy, medium, light		Painful intercourse	☐	☐
Date of LMP		Tubal litigations	☐	☐
Number of live births		Number of still births		
Number of C-sections		Number of miscarriages		

Any pregnancy complications:
Are you pregnant now?

INITIAL:	