Radiation Oncology at Capital Health Medical Center - Hopewell
Adult Patient Information Form

Please take a few moments to complete the following questions before you see your doctor so that we may learn a bit more about you. This will allow your doctor to spend less time asking general questions, and spend more time focusing on your problem and treatment options. Thank you for your assistance, and please bring this completed form with you to your first radiation oncology visit.

Patient Name _____ Date of Birth _____Date _____

Medical History

Do you have or have you had?

	Yes	No		Yes	No		Yes	No
Diabetes	__	__	Lung Problems	__	__	Regional Enteritis	__	__
High Blood Pressure	__	__	Kidney Disease	__	__	Hepatitis	__	__
Heart Problems	__	__	Gout	__	__	Jaundice	__	__
Stroke	__	__	Stomach Problems	__	__	Cancer	__	__
Rheumatic Fever	__	__	Gallbladder Problems	__	__	Hormone Therapy	__	__
Bleeding Problems	__	__	Colitis or diverticulosis	__	__	Chemotherapy	__	__
Anemia	__	__	Chron's Disease	__	__	Previous Radiation	__	__
Asthma	__	__	Lupus	__	__	Scleroderma	__	__

Please list any Other_____

Hospitalizations: (Please include illnesses, injuries and surgeries)

_____ _____ _____
Reason **Date** **Location**

_____ _____ _____
Reason **Date** **Location**

_____ _____ _____
Reason **Date** **Location**

Family History:

	Age	Alive?		Major Illness/ Cause of Death
Mother	_____	Yes __	No __	_____
Father	_____	Yes __	No __	_____
Siblings	_____	Yes __	No __	_____
Siblings	_____	Yes __	No __	_____
Siblings	_____	Yes __	No __	_____
Children	_____	Yes ___	No ___	_____
Children	_____	Yes ___	No ___	_____

Has anyone in your family had?

Cancer	Yes __	No __	What Type _____
Heart disease	Yes __	No __	What Type _____
Liver disease	Yes __	No __	What Type _____
Lung disease	Yes __	No __	What Type _____
Kidney disease	Yes __	No __	What Type _____
Intestinal or colon problems	Yes __	No __	What Type_____
Connective tissue disease	Yes __	No __	What Type _____

Social History:

Smoking

☐ Yes-active (every day) ☐ Cigarettes ☐ Pipe ☐ Cigars
☐ Yes – occasional (some days) ☐ Cigarettes ☐ Pipe ☐ Cigars
☐ Yes – but quit (former) ☐ Cigarettes ☐ Pipe ☐ Cigars
☐ Never
☐ Unknown

#Years_____ #Packs/Day_____ Year Quit_____

Alcohol Consumption

☐ Yes-active (every day) ☐ Beer ☐ Liquor ☐ Wine
☐ Yes – occasional (some days) ☐ Beer ☐ Liquor ☐ Wine
☐ Yes – but quit (former) ☐ Beer ☐ Liquor ☐ Wine
☐ Never
☐ Unknown

#Years_____ #Drinks/Day_____ Year Quit_____

Substance/Products

☐ Illicit or recreational drug use ☐ Chewing Tobacco
☐ Marijuana ☐ Snuff
☐ Narcotics ☐ Other _____

Duration_____Frequency_____

Hazardous Materials

☐ Asbestos ☐ Radiation ☐ Lead ☐ Mercury
☐ Benzene ☐ Coal ☐ Xylene ☐ Red Dye #3
☐ Other Petroleum Products
☐ Other _____

Duration_____Frequency_____

Please complete the following questions:

Have you noted any recent changes with: (Constitutional)	Weight gain or weight loss	Yes __	No __
	Feeling too hot or too cold	Yes __	No __
	Always feeling hungry or thirsty	Yes __	No __
	Problems with sleeping	Yes __	No __
Do you have any problems with: (Head and Neck)	Headaches	Yes __	No __
	Dizziness or lightheadedness	Yes __	No __

	Thyroid Problems	Yes __ No __
	Lumps or swelling in the neck or shoulder	Yes __ No __
	Sore throat	Yes __ No __
	Swallowing	Yes __ No __
	Soreness of the neck or shoulder	Yes __ No __
Do you have any problems with:	Recent changes in vision	Yes __ No __
(Eyes)	Blurred or double vision	Yes __ No __
	Cataracts	Yes __ No __
Do you wear glasses or contact	Glaucoma	Yes __ No __
Lenses? Yes __ No__	Eye infections	Yes __ No __
Do you have any problems with:	Changes in hearing	Yes __ No __
(Ears, Nose and Throat)	Buzzing or ringing in the ears	Yes __ No __
	Frequent earaches or ear infections	Yes __ No __
	Motion sickness	Yes __ No __
Do you wear dentures?	Frequent sinus problems or colds	Yes __ No __
Yes __ No __	Recurrent nose bleeds	Yes __ No __
	Mouth pain or difficulty chewing	Yes __ No __
	Bleeding gums or mouth sores	Yes __ No __
	Taste change	Yes __ No __
	Hoarse voice or difficulty talking	Yes __ No __
Do you have any problems with:	Asthma	Yes __ No __
(Respiratory System)	Tuberculosis	Yes __ No __
	Bronchitis or pneumonia	Yes __ No __
(Respiratory System continued)	Difficulty or painful breathing	Yes __ No __
	Shortness of breath at rest	Yes __ No __
	Cough	Yes __ No __
	Night sweats	Yes __ No __

How many blocks can you walk before you are out of breath? _____

Has this changed recently?	Yes __ No __
Can you climb a flight of steps without resting?	Yes __ No __
On how many pillows do you sleep?	_____
Have you had a cough that has lasted for more than 2 weeks?	Yes __ No __
Have you coughed up phlegm daily for more than 2 weeks?	Yes __ No __
If yes, what color was the phlegm?	_____
Have you had a skin test for TB?	Yes __ No __
What was the result?	Positive __ Negative ____

Do you have problems with:	Chest pain	Yes __ No __
(Cardiovascular System)	Palpations or irregular heart beat	Yes __ No __
	Heart murmur	Yes __ No __
	Heart failure	Yes __ No __
	Ankle swelling	Yes __ No __
	High cholesterol or	Yes __ No __
	Do you have a pacemaker?	Yes __ No __
Do you have problems with:	Nausea or vomiting	Yes __ No __
(Gastrointestinal System)	Vomiting blood	Yes __ No __
	Constipation	Yes __ No __
	Black stools	Yes __ No __
	Blood in stools	Yes __ No __
	Diarrhea	Yes __ No __
Does food ever get stuck, come back up, or make you gag?		Yes __ No __
How many bowel movements do you have per day?		_____

Do you have problems with: (Musculoskeletal System)	Bone or joint pain	Yes __	No __
	Joint swelling or stiffness	Yes __	No __
	Muscle pain or weakness	Yes __	No __
	Sciatica	Yes __	No __
	Broken bones	Yes __	No __
	Have you ever been told you have lupus or arthritis?	Yes __	No __
Do you have problems with: (Neurological System)	Weakness in the arms or legs	Yes __	No __
	Changes in coordination or balance	Yes __	No __
	Paralysis or numbness	Yes __	No __
	Shaking or tremors	Yes __	No __
	Head injury	Yes __	No __
	Loss of consciousness or passing out	Yes __	No __
	Seizures or fits	Yes __	No __
	Difficulty in working with numbers	Yes __	No __
	Difficulty thinking of words	Yes __	No __
	Difficulty speaking	Yes __	No __
	Changes in memory	Yes __	No __
	Changes in handwriting	Yes __	No __
	Difficulty in holding a pen, pencil or cup	Yes __	No__
Do you have problems with: (Skin)	Itching or burning of the skin	Yes __	No __
	Easy bruising or bleeding of the skin	Yes __	No __
	Sores or rashes	Yes __	No __
Do you have problems with: (Mood)	Lack of concentration or memory	Yes __	No __
	Difficulty relaxing	Yes __	No __
	Loss of temper	Yes __	No __
	Being annoyed by little things	Yes __	No __
	Excessive worrying	Yes __	No __
	Excessive crying	Yes __	No __
	Change in personality	Yes __	No __
Do you have problems with: (Genitourinary System)	Painful or frequent urination	Yes __	No __
	Difficulty emptying your bladder	Yes __	No __
	Split stream or difficulty controlling urination	Yes __	No __
	Difficulty starting urination	Yes __	No __
	Urgency to urinate without warning	Yes __	No __
	Dribbling or loss of control of urine	Yes __	No __
	Blood in urine	Yes __	No __
	Kidney stones	Yes __	No __
	Venereal disease (VD)	Yes __	No __
	Venereal warts	Yes __	No __
	Do you experience nighttime urination?	Yes __	No __
	Do you ever urinate and then have to go again in less than ½ hr?	Yes __	No __

For Men: Have you noticed any change in sexual function over the last 2 years? Yes __ No __

Date of last rectal examination _____ Date of last physical examination _____

For Women:

Pregnancies

Have you ever been pregnant? Yes __ No __ If yes, how many times? _____

Did you have any problems with pregnancy? Yes __ No __ Number of children: _____

Did you breastfeed? Yes ___ No___

Age at First Birth _____ # Interrupted Pregnancies _____

Menses

Menses/Period Start Age _____ Last menstrual Period _____Menstrual Cycle Length_____

Menopause

Menopause Status ☐ Pre ☐ Peri ☐ Post ☐ Unknown ☐ No Answer

Age at Menopause_____ Menopause Reason_____

Hormone Use

☐ Contraceptive/Birth Control Hormone Use # of years used _____
☐ Post – Menapause Use # of years used _____
☐ Other Hormone Use # of years used _____

GYN History

Have you had any bleeding or discharge from the vagina? Yes __ No __
Have you ever had any operations or infections of the uterus, fallopian tubes or ovaries? Yes __ No __
Do you have any lumps, swelling or tenderness of the breasts? Yes __ No __
Do you have pain or bleeding with sexual intercourse? Yes __ No __
Date of last pelvic exam: _____ Date of last PAP smear: _____
Date of last breast exam: _____ Date of last mammogram: _____
Date of last general physical examination _____

Please do not write below this line

For Physician Use Only

☐ All other systems are negative
☐ Review of systems unobtainable
Reason: _____
☐ History obtained from (other source) _____
☐ No other source available

_____ _____
Attending Physician's Signature Date