St Joseph Hospital Radiation Oncology Department
Patient History

Patient name:____ **Date of birth:**____________________

Medical History:

- ○ Heart attack
- ○ Heart disease
- ○ Pacemaker/Defibrillator
- ○ High blood pressure
- ○ High Cholesterol
- ○ Peripheral vascular disease
- ○ Asthma
- ○ COPD
- ○ Blood clot (lung or extremity)
- ○ Breast biopsies
- ○ Broken bones
- ○ Stroke
- ○ Thyroid problems
- ○ Anemia
- ○ Lupus, Fibromyalgia or Scleroderma
- ○ Rheumatoid disease
- ○ Inflammatory bowel disease/Crohn's
- ○ Diabetes
- ○ Arthritis
- ○ Infectious disease (MRSA, VRE, ESBL, TB, Meningitis)
- ○ Psychiatric:_________________________
- ○ Other cancers:______________________
- ○ Prior radiation treatment
- ○ Other:_________________________

Previous Surgeries	
Name of Operation	**Date**

Family History:

Father: if living, age: _________ If deceased, age at death: _______ Cause: ___________________________
Mother: if living, age: _________ If deceased, age at death: ______ Cause: ___________________________
How many sisters do you have? ________ How many brothers do you have? __________

Family Members With Cancer (i.e. parents, children, siblings, paternal/maternal aunts/uncles, cousins)				
Relationship	Type of Cancer	Age at Diagnosis	Living (✓)	Deceased (✓)

Social History:

What is your marital status? Single Married Domestic Partnership Divorced Separated Widowed
Who lives at home with you? ____
Are you currently working? Yes No What is/was your occupation? ______________________________
Have you ever smoked (cigarettes/cigars/pipe/vape/electronic cigarettes)? Yes No
If yes how much per day? _________________ How many years did you smoke? _______________
Have you quit smoking? Yes No How long ago did you quit? ________________
Do you drink alcoholic beverages? Yes No If yes, how much per week?____________________
Have you quit drinking alcoholic beverages? Yes No If yes, how long ago?____________________
Have you ever used illicit drugs? Yes No If yes what? __________________How long? _____________
Have you used medical marijuana? Yes No If yes, how often?__________________________________

Please check any symptoms you are <u>currently</u> having:

General/emotional:

- ○ Fatigue
- ○ Night sweats
- ○ Fever or chills
- ○ Blurry, double, worsening vision
- ○ Dental problems
- ○ Depression or Anxiety

Ear, Nose & Throat:

- ○ Difficulty swallowing
- ○ Dry mouth
- ○ Voice changes
- ○ Nose bleeds

Neurological:

- ○ Headaches
- ○ Seizures
- ○ Numbness, where?___________________
- ○ Weakness, where?___________________

Respiratory:

- ○ Dry cough
- ○ Productive cough
- ○ Blood in sputum
- ○ Short of breath (resting or with activity)

Cardiovascular:

- ○ Chest pain
- ○ Irregular heart beats
- ○ Congestive heart failure
- ○ Bleeding
- ○ Bruising easily

Gastrointestinal:

- ○ Weight loss: If yes, how much & in what time frame? _______________________
- ○ Change in appetite
- ○ Reflux
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Blood in stool
- ○ Incontinent of stool
- ○ Hemorrhoids

Urinary:

- ○ Frequent urination
- ○ Difficulty urinating/hesitation
- ○ Painful urination
- ○ Blood in urine
- ○ Urine leakage/incontinence
- ○ Urinating at night, how many times?___________________

Gynecological

- ○ Vaginal bleeding
- ○ Foul smelling discharge
- ○ Painful intercourse

Dermatology:

- ○ Skin problems
- ○ Muscle spasms/pain
- ○ Jaundice

<u>Pain</u>

Are you experiencing pain? Yes No If yes, where:______________________________
When did you first start having pain?____
Describe your pain (constant, intermittent, sharp, achy, dull, burn, etc.):______________________
____
What is the highest your pain has been in the last 24 hours? (0=no pain, 10=worst pain)_________
Does anything make the pain worse?____
Does anything make the pain better?____
What medications do you use for pain?____

<u>Female Patients:</u>

Are you now, or is there any chance that you might be pregnant? Yes No
Number of Pregnancies_______ Number of Deliveries_______ Age at first childbirth________
Are you currently having menstrual periods: Yes No If yes, date of last period_________
If no, age at menopause_______ Age of first period_______
Have you ever taken:

Birth Control Medication Yes No If yes, how many years?_______
Hormone Replacement Medication Yes No If yes, how many years?_______
Fertility treatment Yes No If yes, what and how long?_________________________

Date of last mammogram?______________Date of last Pap Smear?______________

Staff use only: Reviewed with patient by nursing____Date____________

Medication List

Please include all prescription, over the counter medications, vitamins, herbal/nutritional supplements and medications administered at doctor's offices (for example injections, intravenous infusions, chemotherapy, etc.)

Allergies (reaction):____

Medication/supplement Name	Dose	Times taken per day (example 1,2, as needed, etc)	Reason

St.JosephHealth
St. Joseph Hospital
The Center for
Cancer Prevention and Treatment
A member of the St.Joseph Hoag Health alliance

To protect your privacy, if we need to contact you during treatment, please list (in order of preference) which number(s) to try:

Phone #1________________________________ cell home work
Name and Relationship to patient____________________________
May we leave a message? Y N
Special instructions: ____

Phone #2________________________________ cell home work
Name and Relationship to patient____________________________
May we leave a message? Y N
Special instructions: ____

Phone #3__________________________________ cell home work
Name and Relationship to patient____________________________
May we leave a message? Y N
Special instructions: ____

Please list the physicians you are currently seeing and their phone numbers:

Primary Physician: _____________________________ (_____) _______________

Referring Physician: ____________________________ (_____) _______________

Surgeon: _______________________________________ (_____) _______________

Oncologist: _____________________________________ (_____) _______________

Family member or representative authorized to receive medical information:
____

This person will be required to provide your name, date of birth and password designated by you in order to receive any information over the phone due to HIPPA privacy laws.

Please provide the password you would like used to release information:
____