St. Joseph's Hospital Radiation Oncology Department

Patient's Name: _____ Date of Birth: _____

Please answer each question by checking either "no" or "yes".

GENERAL	**NO**	**YES**
1. Has your child's activity level decreased?	___	___
2. Has your child's appetite or weight decreased?	___	___
3. Has your child been having trouble sleeping?	___	___
4. Is your child's growth and development abnormal?	___	___
5. Is your child's speech and language abnormal?	___	___
6. Has your child had any broken bones?	___	___
7. Has your child had any prior radiation?	___	___
8. Does your child have any infections/infectious disease?	___	___

RESPIRATORY	**NO**	**YES**
1. Does your child have a cough?	___	___
2. Does your child have wheezing or asthma?	___	___
3. Does your child have problems with shortness of breath?	___	___

HEENT	**NO**	**YES**
1. Does your child have problems with vision?	___	___
2. Does your child have problems hearing?	___	___
3. Does your child have a sore throat or pain with swallowing?	___	___

CARDIOVASCULAR	**NO**	**YES**
1. Does your child get chest pain?	___	___
2. Does your child get palpitations or an irregular heartbeat?	___	___
3. Does your child have a pacemaker?	___	___
4. Does your child have high blood pressure?	___	___
5. Has your child had any blood clots?	___	___
6. Has your child had a stroke?	___	___

HEMATOPOETIC/ENDOCRINE	**NO**	**YES**
1. Does your child have easy bruising or bleeding?	___	___
2. Has your child had any problems with anemia?	___	___
3. Does your child have excessive thirst?	___	___
4. Does your child have excessive urination?	___	___
5. Does your child have diabetes?	___	___
6. Does your child have any thyroid problems?	___	___

BIRTH HISTORY	**NO**	**YES**
1. Was your child born prematurely?	___	___

2. Describe any difficulties: _____

_____

DERMATOLOGIC	**NO**	**YES**
1. Does your child have skin rashes?	___	___
2. Does your child have acne?	___	___
3. Does your child have any concerning moles or lumps?	___	___
4. Does your child have Lupus, Scleroderma or other autoimmune disease?	___	___

NEUROLOGICAL	**NO**	**YES**
1. Has your child experienced headaches?	___	___
2. Has your child had fainting spells?	___	___
3. Has your child had serious head injuries?	___	___

PSYCHOLOGICAL/PSYCHIATRIC	**NO**	**YES**
1. Is your child frequently defiant or uncooperative?	___	___
2. Does your child have difficulty getting along with others – children or teachers?	___	___
3. Does your child seem anxious or depressed?	___	___

GI	**NO**	**YES**
1. Does your child have problems with diarrhea?	___	___
2. Does your child have problems with constipation?	___	___
3. Does your child have abdominal pain?	___	___
4. Does your child have vomiting?	___	___
5. Does your child have inflammatory bowel disease/Crohn's?	___	___

GU	**NO**	**YES**
1. Does your child have poor bladder control?	___	___
2. Do you have any concerns about your child's sexual development?	___	___

SOCIAL HISTORY	**NO**	**YES**
1. Is your child attending school? Grade? _____	___	___
2. Is your child exposed to cigarette smoke?	___	___
3. Are you concerned about your child using tobacco?	___	___
4. Are you concerned about your child using illegal drugs?	___	___
5. Are you concerned about your child using alcohol?	___	___

6. Is your child's performance at school: (please circle one)
above average average below average

Has your child had any surgeries? Please list the type and date of surgeries. _____

_____

_____

Are there any problems with anesthesia for your child or your family? _____

_____

_____

Family History:

Father: if living, age: _____ If deceased, age at death: _____ Cause: _____

Did father or any relatives on father's side (i.e. grandparent, aunt, uncle) have cancer?_____

_____

Mother: if living, age: _____ If deceased, age at death: _____ Cause: _____

Did mother or any relatives on mother's side (i.e. grandparent, aunt, uncle) have cancer?_____

_____

How many siblings does your child have? _____ Did any have cancer? If yes, please list type of cancer and age at diagnosis: _____

_____

Who lives in your child's home? (list relationships)_____

Pain:

Is your child experiencing any pain? Yes No If yes:

When did your child first start having the pain? _____

Where in your child's body is the pain located? _____

Describe the pain (i.e. sharp, dull, cramp, ache, burn, etc.) _____

When the pain is at its worst, how would your child rate it from 0-10? (0 – no pain, 10 – most pain)_____

Does your child take medication for pain? Yes No If yes, what? _____

Does anything make the pain worse? _____ Better? _____

Female Patients:

Has your child started her period? Yes No If yes, at what age? _____

Is your child now, or is there any chance, that your child may be pregnant? Yes No

Has your child been pregnant in the past? Yes No If yes, number of pregnancies? _____ Number of deliveries? _____

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

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:

_____