

Radiation Oncology Patient Information

Patient Name _____ DOB _____ Date _____
 What do you like to be called? _____ Place of Birth: _____
 Primary Language: _____ Preferred Language: _____
 Cell Phone _____ Home Phone _____ Other Phone _____
 Email _____ Are you participating in a clinical trial? _____

Family/Support:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

Advance Directive	Yes	No	
Do you have an Advance Directive?			What type? *Please bring it with you to your visit
If not, would you like more information?			

Topic	Yes	No	Comments
Do you understand why you are meeting with us?			
Do you reside somewhere other than a private home?			Retirement facility Board/Care Name:
Do you smoke tobacco?			How long? How much?
Do you use smokeless tobacco?			How long? How much?
Would you like smoking cessation info?			
Did you ever smoke tobacco?			How long? How much?
Do you drink alcohol?			↑ Never ↑ Rarely ↑ Moderately ↑ Daily
Will transportation for daily treatments be difficult for you?			If yes, please explain:
Is it possible you are pregnant?			Date of last menstrual period:
Do you feel spiritually well?			
Are you currently experiencing depression/ anxiety?			How do you usually cope with stress?
Do you have any hobbies?			Please list:
Are you retired?			From:
Are you employed?			Occupation:

(Please continue onto back of form)



Surgical History. Please list any surgeries and the approximate date/year—

Surgery	Date	Surgery	Date

Do you have any allergic reactions to Medications/Food/Latex?

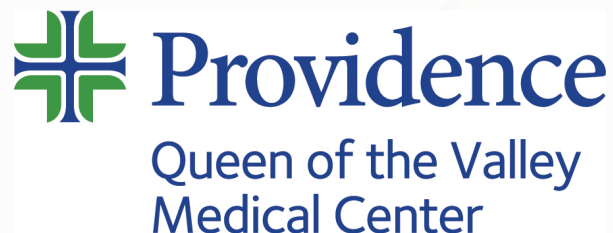
Medical Problems—Please “X” any that apply to you

	Please “X” and comment		Please “X” and comment
Anemia/Bleed easily		Previous Radiation Therapy	
Blood clots		Previous Chemotherapy	
Cardiac Issues **Cardiologist Name:		Implantable Device (**Pacemaker, Port....)	
Chest pain		Thyroid Issues	
Arthritis/Osteoporosis		Diabetes	
Constipation/Diarrhea		High blood pressure	
Convulsion/ Seizure		Gastro-Intestinal Issues	
Stroke		Colostomy bag	
Hepatitis		Lung/Pulmonary Issues	
Kidney Problems		Lupus/Scleroderma	
Dialysis		Dental/Oral issues: **Dentist:	

Please list any medical problems not listed above, past and current:

Medications—Please list any medications (prescription and over the counter) that you are currently taking. Please utilize another sheet of paper.

****Preferred Pharmacy** _____



Physician and Hospital Information Form

In order for us to have a better understanding of your condition and keep your physician's informed of your progress, please complete this form, listing all doctor's care you are currently under and any doctor or hospital that has treated you for your current condition. Include the hospital where you had your surgery or any diagnostic testing. Use the reverse side if you need additional space.

Doctor's Name: _____

Title: _____

Name of Group: _____

Office Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Doctor's Name: _____

Title: _____

Name of Group: _____

Office Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Doctor's Name: _____

Title: _____

Name of Group: _____

Office Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Doctor's Name: _____

Title: _____

Name of Group: _____

Office Street Address: _____ City: _____ State: _____ Zip: _____

Hospital's Name: _____

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

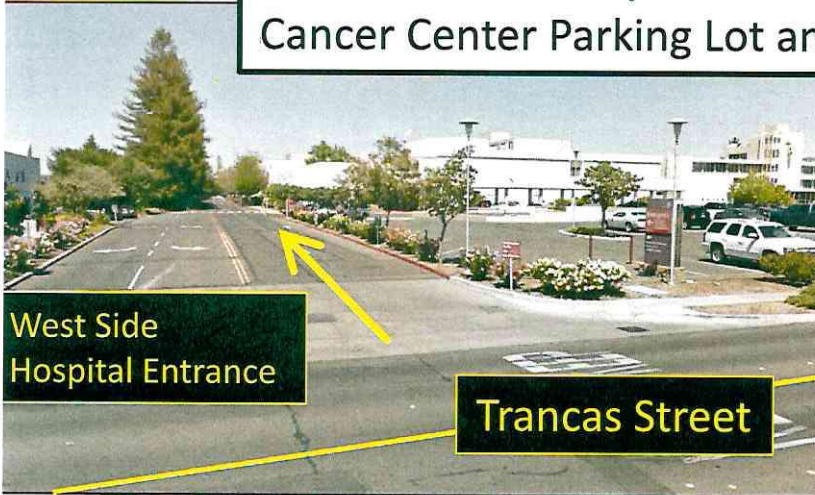
Phone: _____ Fax: _____

Hospital's Name: _____

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

Phone: _____ Fax: _____

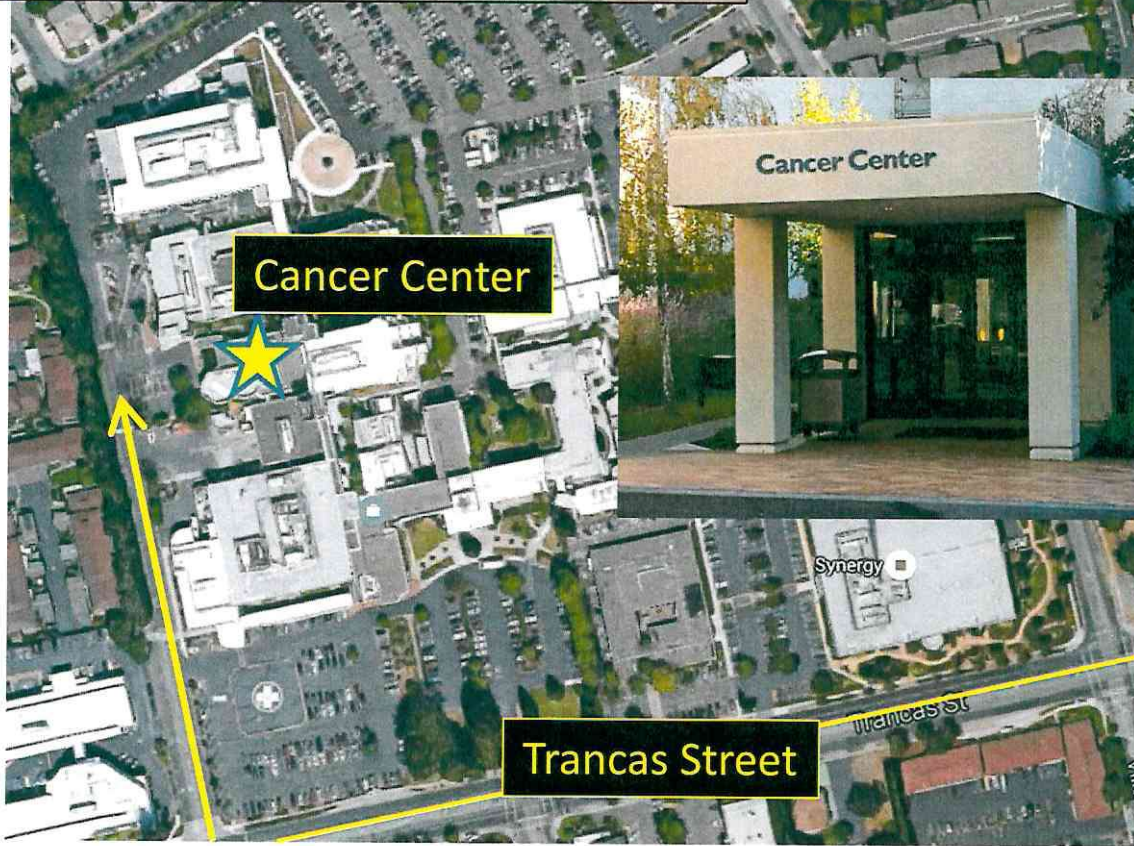
Queen of the Valley Medical Center
Cancer Center Parking Lot and Entrance



West Side
Hospital Entrance

Trancas Street

Queen of the Valley Medical Center
1000 Trancas St.
Napa, CA 94558

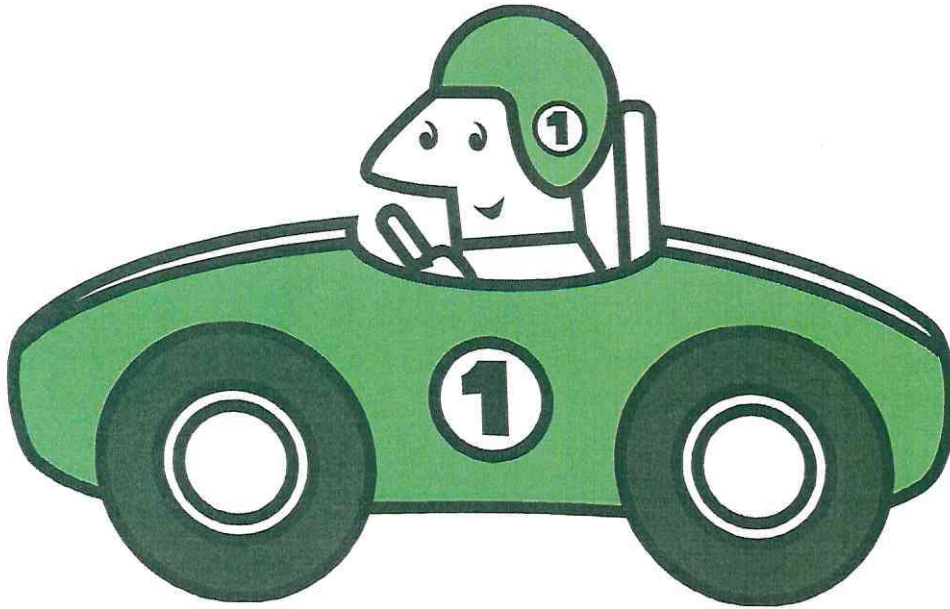


Cancer Center

Trancas Street



Enter from Trancas Street on the West Side of Campus
Travel Past the Emergency Department (ED)
Park in front of the Cancer Center (CC)
It is just before the Maternity Center (MC)



**Cancer Center Patient
Parking Pass**

Please display on dash while
visiting the Cancer Center



Providence

Queen of the Valley
Medical Center