



Department of Radiation Oncology  
Patient's Health History

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: past or present \_\_\_\_\_ If retired please circle yes \_\_\_\_\_

Living Will [ ] Yes [ ] No DNR ( ) Yes ( ) No

Do you have Advanced Directives? HCP ( ) Yes ( ) No

**DIAGNOSIS:**

Presenting problem and patient's own history of problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**1. DIAGNOSTIC TESTING (ct scan, mri, pet ct, mammogram, ultrasound) where and date**

- Please Fill this information out in detail, it is very important

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

**2. PAST SURGICAL, BIOPSIES and INJURY HISTORY**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_



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**SOCIAL HISTORY**

Married  Single  Widowed  Divorced  Separated

Occupation \_\_\_\_\_

Level of Education: some high school  high school  2-year college   
4-year college  graduate school

Do you drink alcoholic beverages? No  Yes

If yes, how much? Social  moderate (1-2 drinks/day)  Heavy (3 or more/day)

Do you smoke or use smokeless tobacco now? No  Yes

If yes, how much? \_\_\_\_\_ Packs per day for \_\_\_\_\_ years

Did you smoke in the past? No  Yes

If yes, how much? \_\_\_\_\_ Pack per day for \_\_\_\_\_ years

Have you ever been exposed to occupational hazards? (Lead, asbestos, chemical solvents, etc.)

No  Yes  \_\_\_\_\_

Have you ever been exposed to environmental hazards? (Radon, toxic wastes, second-hand smoke, pollution, etc.) No  Yes

If yes, what and when? \_\_\_\_\_

**Travel History within the past two years:**

\_\_\_\_\_

\_\_\_\_\_

**VACCINATION HISTORY**

Pneumococcal	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Date _____
Influenza	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Date _____
Varicella	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Date _____
PPD( screening)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Date _____

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**FAMILY HISTORY**

	<b>Alive</b>	<b>Deceased</b>	<b>Cause of Death</b>	<b>Age</b>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	<b>Alive</b>	<b>Deceased</b>	<b>Cause of Death</b>	<b>Age</b>
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Is there a history of cancer in your family? No  Yes

If yes, please list:

	<b>Relative</b>	<b>Type of Cancer</b>	<b>Alive</b>	<b>Deceased</b>	<b>Age</b>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

**PAIN**

Do you have pain? No  Yes

From a scale of 1-10 1 being the least and 10 being the worst what is your pain right now? \_\_\_\_\_

Where is the pain? \_\_\_\_\_

How long does the pain last? \_\_\_\_\_

Does the pain prevent you from doing normal activities? No  Yes

Are you taking any medication for pain? No  Yes

If yes, what? \_\_\_\_\_

Pain Evaluation Scale: 1 2 3 4 5 6 7 8 9 10 or greater



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**REVIEW OF SYSTEMS** *continued*

**Nursing Notes**

**Musculoskeletal**

- 32. Joint swelling
- 33. Arthritis
- 34. Cramps
- 35. Arm or leg weakness
- 36. Numbness
- 37. Difficulty with balance
- 38. Bone pain

**Skin/Breast**

- 39. Rash
- 40. Itching
- 41. Sores
- 42. Healing Incision
- 43. Eczema
- 44. Psoriasis

**Neurological**

- 45. Seizures
- 46. Vertigo
- 47. Headaches
- 48. Dizziness

**Psychiatric/Emotional**

- 49. Depression
- 50. Anxiety
- 51. Memory Loss

**Endocrine**

- 52. Diabetes
- 53. Thyroid

**Hematologic/Lymphatic**

- 54. Easy Bruising
- 55. Anemia
- 56. Leukemia

**Allergic/Immunologic**

- 57. Allergies
- 58. Seafood
- 59. Latex
- 60. Immune system problems

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**RN Use Only:**

Age \_\_\_\_\_ Current Weight \_\_\_\_\_ Usual Weight \_\_\_\_\_ Height \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Temperature \_\_\_\_\_

**PRECAUTIONS:**

**Falls:** \_\_\_\_\_ No  Yes

Assessment: \_\_\_\_\_  
\_\_\_\_\_

**Isolation:** \_\_\_\_\_ No  Yes

Description: \_\_\_\_\_  
\_\_\_\_\_

**Birth Control Education:**

**Methods/Discussion:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birth Control options and education has been discussed with me, I understand the importance of not becoming pregnant at this time:

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Reviewed by (RN):* \_\_\_\_\_ *Date:* \_\_\_\_\_



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**Physician Use Only:**  
History and Physical:

**PHYSICAL EXAM:**

General Appearance:

HENT:

Neck:

Cardiovascular:

Skin and Breast:

Respiratory:

Abdomen:

GU:

Musculoskeletal:

Neurological:

Other:

**Plan of Care:**



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*Radiation Oncologist Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_