SOUTH COUNTY HEALTH

RADIATION THERAPY HEALTH HISTORY

All information is kept strictly confidential.

Name____________________ DOB: ____________

Reason for visit: ____________________ Date: ____________

Age ________ Date of last physical exam: ____________

MEDICATIONS: List medications you are currently taking including aspirin, ibuprofen, over the counter medication and eye drops.

DRUG	DOSE	FREQUENCY	DRUG	DOSE	FREQUENCY
1.			4.		
2.			5.		
3.			6.		

ALLERGIES: List allergies & reactions to medications and substances (ie. radiology dye, etc.)

DRUG / SUBSTANCE	TYPE OF REACTION	DRUG / SUBSTANCE	TYPE OF REACTION
1.		4.	
2.			
3.			

Do you currently see an allergist? Yes ☐ No ☐

If yes, allergist's name: ____________

CONDITIONS & MEDICAL HISTORY: Check (x) all that apply:

- ☐ Acid reflux
- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Bronchitis/pneumonia
- ☐ Cancer (Type:________)
- ☐ Carpal tunnel
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital heart defect
- ☐ Congestive heart failure
- ☐ COPD OR Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart bypass surgery
- ☐ Heart disease
- ☐ Heart stent
- ☐ Heart valve problem
- ☐ Heart valve surgery
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ High blood pressure in pregnancy
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg artery blockage
- ☐ Liver disease
- ☐ Multiple sclerosis
- ☐ Pacemaker/Defibrillator
- ☐ Pre-Eclampsia
- ☐ Prostate problem
- ☐ Radiation therapy (Body location:________)
- ☐ Sickle cell anemia
- ☐ Skin disease
- ☐ Sleep apnea
- ☐ Spinal stenosis
- ☐ Stroke/TIA seizure
- ☐ Tendon rupture
- ☐ Thyroid disease
- ☐ Ulcer
- ☐ Other:

SURGERIES: List all previous procedures.

TYPE/BODY AREA	APPROXIMATE DATE	TYPE/BODY AREA	APPROXIMATE DATE
1.		4.	
2.		5.	
3.		6.	

RADIATION RELATED HISTORY

Have you had radiation previously? Y ☐ N ☐

If Yes, what area of body ________________ *When* __________________ *What Facility* ___________________________________

Have you had previous cancer diagnosis Y ☐ N ☐ *If Yes what was diagnosis* ____

Have you previously had chemotherapy Y ☐ N ☐ *If Yes, What facility?* ____

Does your oncologist prescribe any oral or IV therapies for your cancer? Y ☐ N ☐ *If Yes, date of last therapy* ____________________

Have you ever been diagnosed with inflammatory bowel disease? Y ☐ N ☐

Have you ever been diagnosed with Crohn's Y ☐ N ☐

Have you ever been diagnosed with Ulcerative Colitis Y ☐ N ☐

Have you ever been diagnosed with an autoimmune disease? Y ☐ N ☐ *If Yes which one?* ______________________________

DO YOU HAVE ANY OF THE FOLLOWING:

Pacemaker Y ☐ N ☐

Defibrillator Y ☐ N ☐

Spinal Stimulator Y ☐ N ☐

Insulin Pump Y ☐ N ☐

SOCIAL HISTORY & HEALTH HABITS:

GENDER IDENTITY

☐ Male

☐ Female

Other: ___________

MARITAL STATUS

☐ Married

☐ Single

☐ Divorced

☐ Widowed

LIVING SITUATION

☐ At home

☐ Nursing facility

☐ With relative

Other: _______________

Do you, or have you ever used tobacco? Y ☐ N ☐ If yes, how much per day __________ How many years? __________
When did you quit? ___________________

Do you use E-cigarettes/vape? Y ☐ N ☐ Former, quit _____ years ago

Do you drink coffee/tea? Y ☐ N ☐ # cups/day ______________

Do you use energy drinks? Y ☐ N ☐

Do you use marijuana or other drugs? Y ☐ N ☐

Have you ever used cocaine? Y ☐ N ☐

Do you drink alcohol? Y ☐ N ☐ # drinks per week (avg.) _______

Do you exercise regularly? Y ☐ N ☐ Type: ______________________

OCCUPATIONAL HISTORY:

Current Employment

☐ Full time

☐ Part time

☐ Retired

List major jobs you held throughout your life:

____

____

____

Have you ever worked with asbestos? YES ☐ NO ☐

Have you been exposed to fumes, dust, or solvents? YES ☐ NO ☐

FAMILY HISTORY: (Applies to biological parents, siblings, children only) *If family history is unknown, check here* ☐

	YES	RELATION / AGE DIAGNOSED		YES	RELATION / AGE DIAGNOSED
Aneurysm	☐	______	Heart attack	☐	______
Blood clot / embolism	☐	______	Heart rhythm problem	☐	______
Bypass surgery	☐	______	Heart stent	☐	______
Congestive heart failure	☐	______	Heart valve replacement	☐	______
Died pre-age 55	☐	______	High blood pressure	☐	______
Died suddenly	☐	______	Stroke	☐	______

SYMPTOMS: Check (x) all symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Hot flashes
- ☐ Unusual Weight Loss/Gain
- ☐ Night sweats
- ☐ Extreme Fatigue

EYES
- ☐ Blurred vision
- ☐ Double vision
- ☐ Sudden Visual Change
- ☐ Loss of Vision
- ☐ Redness

NOSE, EARS, THROAT
- ☐ Difficulty swallowing
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Runny nose

CARDIOVASCULAR
- ☐ Chest pain / discomfort / pressure
- ☐ Poor circulation
- ☐ Rapid / skipping heartbeat
- ☐ Swelling of ankles or legs
- ☐ Fainting
- ☐ Lightheadedness

RESPIRATORY
- ☐ Chronic / frequent cough
- ☐ Shortness of breath (Seated/standing/laying flat/bending)
- ☐ Spitting phlegm / blood
- ☐ Wheezing / snoring
- ☐ Daytime sleepiness

GASTROINTESTINAL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Vomiting
- ☐ Stomach pain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent / difficulty urinating
- ☐ Lack of bladder control
- ☐ Kidney stones

MUSCLE & JOINTS
- ☐ Back aches
- ☐ Pain / stiffness / swelling
- ☐ Leg cramps
- ☐ Swollen joints
- ☐ Muscle aches

SKIN / BREAST
- ☐ Breast lump
- ☐ Discharge from breast
- ☐ Rash
- ☐ Sore that won't heal
- ☐ Change in skin color

NEUROLOGICAL
- ☐ Headache
- ☐ Seizures
- ☐ Dizziness / balance difficulties
- ☐ Numbness / tingling

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety

ENDOCRINE
- ☐ Excessive sweating
- ☐ Thirst
- ☐ Weight gain
- ☐ Heat / cold intolerance

ALLERGIC
- ☐ Itching
- ☐ Hives / Rash
- ☐ Wheezing

HEMATOLOGICAL LYMPHATIC
- ☐ Ankle/legs swelling
- ☐ Bruise / bleed easily
- ☐ Nosebleed

I certify that the above information is correct to the best if my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that i may have made in the completion of this form.

Signature ______________________ Date ______________

I have reviewed the above information and made any changes that have occurred since my last visit here.

Initials-Date ______________ Initials/Date ______________ Initials/Date ______________

Physician Signature ______________________ Date ______________