Office Use Only

GARNET HEALTH MEDICAL CENTER
RADIATION ONCOLOGY DEPARTMENT
PATIENT PROFILE

Name _____ Date _____
DOB _____ Spouse's/Significant Other's Name _____

PAST HISTORY:

Have you ever had any of the following:

	No	Yes		No	Yes
Diabetes Mellitus	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐
Emphysema/COPD	☐	☐	Degenerative Arthritis	☐	☐
High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐
High Cholesterol	☐	☐	Other Autoimmune Disease	☐	☐
Peptic ulcer	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Depression	☐	☐
Implantable Cardiac Device	☐	☐	Psychological Illness	☐	☐
Seizure Disorder	☐	☐	Liver Disease	☐	☐
Cancer _____	☐	☐	Other _____	☐	☐

Are there any other physicians involved in your medical care? ☐ No ☐ Yes
If yes, please list: _____

PAST SURGERIES (Indicate type of surgery and year):

1. _____
2. _____
3. _____
4. _____

PAST INJURIES (indicate type of injury and year): _____
_____

PRIOR TREATMENT HISTORY:

Have you ever had any of the following?

Radiation Treatments ☐No ☐Yes
If yes; where and when? _____
Chemotherapy ☐No ☐Yes
If yes; where, when, and what kind? _____
_____
How many treatments did you receive? _____
When was your last treatment? _____
Hormone Therapy ☐No ☐Yes
If yes; where, when, and what kind? _____
_____

ARE YOU GOING TO RECEIVE CHEMOTHERAPY: ☐ No ☐ Yes ☐ Don't Know
If yes; what drug/drugs and where? _____

For Thyroid patients:

Did you have any CT scan with contrast within the past 3 months? ☐ No ☐ Yes

PRESENT MEDICATIONS (List medication name, dose, and how often taken):

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

Do you have any allergies to:
Medications ☐ No ☐ Yes
If yes; please specify: _____

For Nurses' Use:
Weight : _____
Height : _____
BP : _____
PR : _____
RR : _____
O2 Sat : _____
Size : _____
LP:_____ RP :_____
LF :_____ RF :_____
LA:_____ RA :_____

Latex Allergy ☐ No ☐ Yes
Food ☐ No ☐ Yes
If yes; please specify: _____
Seasonal/Environmental ☐ No ☐ Yes
If yes; please specify: _____

FAMILY HISTORY:

	Alive	Deceased	Cause of Death	Age
Mother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Siblings	☐	☐	_____	_____
	☐	☐	_____	_____
	☐	☐	_____	_____
Children	☐	☐	_____	_____
	☐	☐	_____	_____
	☐	☐	_____	_____

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

If yes; please list:

	Relative	Type of Cancer	Alive
1.	_____	_____	☐ No ☐ Yes
2.	_____	_____	☐ No ☐ Yes
3.	_____	_____	☐ No ☐ Yes
4.	_____	_____	☐ No ☐ Yes

SOCIAL HISTORY/HABITS:

Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____

Level of Education:

☐ Some high school ☐ High school graduate ☐ Some college
☐ College graduate ☐ Graduate School (Masters/Doctoral degree)

Alcohol History:

Do you or did you drink alcoholic beverages? ☐ No ☐ Yes ☐ Quit, when? _____
If yes (or quit); how much? ☐ Social ☐ Moderate (1 - 2 drinks/day) ☐ Heavy (3+/day)

Tobacco History:

Do you or did you smoke or use smokeless tobacco?
☐ No ☐ Yes ☐ Quit, when? _____
If yes (or quit); how much? _____ packs per day for _____ years.

Occupational Hazards:

Have you ever been exposed to occupational hazards such as lead, asbestos, chemical solvents, etc? ☐ No ☐ Yes
If yes; please specify: _____

Environmental Hazards:

Have you ever been exposed to environmental hazards such as radon, toxic waste, secondhand smoke, pollution, etc?
☐ No ☐ Yes
If yes; please specify: _____

HOME/PERSONAL ISSUES:

Do you have special needs or concerns with any of the following:

	No	**Yes**	
Child Care	☐	☐	If yes; please specify: _____
Spiritual Needs	☐	☐	If yes; please specify: _____
Financial concerns	☐	☐	If yes; please specify: _____
Transportation	☐	☐	If yes; please specify: _____
Dressing yourself	☐	☐	If yes; please specify: _____
Making your meals	☐	☐	If yes; please specify: _____
Anxieties or fears	☐	☐	If yes; please specify: _____
Other needs	☐	☐	If yes; please specify: _____

WOMEN ONLY: (Men please proceed to Review of Systems)

Name of Gynecologist: _____

Date of last gynecologic exam/Pap smear: _____

Menstrual History: Age at onset: _____ First day of your last period: _____

Age at menopause: _____

Do you or did you use birth control pills? ☐ No ☐ Yes

If yes; what, when and for how long? _____

_____

Pregnancies: Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Age at first live birth: _____

REVIEW OF SYSTEMS:

Do you have any of the following:

Constitutional/General

☐ Weight Loss ☐ Weight Gain ☐ Weight Stable

If Gain or Loss; how much? _____ pounds in _____ (week/months/years)

	No	Yes
Loss of appetite	☐	☐
Fatigue/Weakness	☐	☐
Trouble sleeping	☐	☐
Trouble maintaining sleep	☐	☐
Fever	☐	☐
Chills	☐	☐
Night sweats	☐	☐

Other (please specify): _____

Eyes/Ears/Nose/Throat/Mouth	**No**	**Yes**
Hearing problems	☐	☐
Hearing loss	☐	☐
If yes: ☐ Left ☐ Right ☐ Both		
Ringing in the ears	☐	☐
Earache	☐	☐
If yes: ☐ Left ☐ Right ☐ Both		
Drainage from the ears	☐	☐
Hoarseness of the voice	☐	☐
Difficulty of swallowing	☐	☐
Pain on swallowing	☐	☐
Bleeding	☐	☐
If yes; from where?: _____		
Stuffy nose	☐	☐
Sore throat	☐	☐
Dry mouth	☐	☐
Blurring of vision	☐	☐
Double vision	☐	☐
Blindness	☐	☐

Dental condition: ☐ Good ☐ Fair ☐ Require dental consultation

	No	Yes
Dentures	☐	☐
If yes: ☐ Upper ☐ Lower ☐ Both		

Respiratory/Pulmonary	**No**	**Yes**
Cough	☐	☐
Sputum	☐	☐
Coughing up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Painful breathing	☐	☐
Trouble laying flat	☐	☐
If yes: How many pillows do you sleep with: _____		
Use oxygen at home	☐	☐ If yes; how many liters: ____

Other (please specify): _____

Cardiovascular	**No**	**Yes**
Chest pain or discomfort	☐	☐
Chest tightness	☐	☐
Palpitations	☐	☐
Chest pain when walking	☐	☐
Leg cramping	☐	☐
Musculoskeletal	**No**	**Yes**
Leg swelling	☐	☐
Joint pain	☐	☐
Joint swelling	☐	☐
Muscle pain	☐	☐
Redness of joints	☐	☐
Stiffness	☐	☐
Bone pain	☐	☐
Genitourinary	**No**	**Yes**
Incontinence	☐	☐
Burning, discomfort or pain on urination	☐	☐
Blood in the urine	☐	☐
Decreased interest in sex	☐	☐

(Check what best describe you)

In the past month:	**Not at all**	**Less than 1 in 5 times**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	☐	☐	☐	☐	☐	☐
2. Frequency How often have you had to urinate less than every two hours?	☐	☐	☐	☐	☐	☐
3. Intermittency How often have you found you stopped and started again several times when you urinated?	☐	☐	☐	☐	☐	☐
4. Urgency How often have you found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
5. Weak Stream How often have you had a weak urinary stream?	☐	☐	☐	☐	☐	☐
6. Straining How often have you had to strain while urinating?	☐	☐	☐	☐	☐	☐
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**
7. Nocturia How many times did you typically get up at night to urinate?	☐	☐	☐	☐	☐	☐

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Women Only:	**No**	**Yes**
Vaginal pain/discomfort	☐	☐
Vaginal discharge	☐	☐
Vaginal bleeding	☐	☐

Men Only: (For those who may receive therapy to the Prostate or Pelvis, check what best describe you)

Over the past 6 months:					
1. How do you rate your confidence that you can get and keep an erection?	Very low ☐	Low ☐	Moderate ☐	High ☐	Very high ☐
2. When you had erections with sexual stimulation how often were your erections hard enough for penetration?	Almost never/ never ☐	A few times (much less than half the time) ☐	Sometimes (about half the time) ☐	Most times (much more than half the time) ☐	Almost always/ always ☐

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never/ never ☐	A few times (much less than half the time) ☐	Sometimes (about half the time) ☐	Most times (much more than half the time) ☐	Almost always/ always ☐
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult ☐	Very difficult ☐	Difficult ☐	Slightly difficult ☐	Not difficult ☐
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never/ never ☐	A few times (much less than half the time) ☐	Sometimes (about half the time) ☐	Most times (much more than half the time) ☐	Almost always/ always ☐

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Gastrointestinal	**No**	**Yes**
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Heartburn/indigestion	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Change in bowel habits	☐	☐
Rectal bleeding	☐	☐
Feeding tube	☐	☐

If yes, how many cans per day: _____

Skin/Breasts	**No**	**Yes**
Rash	☐	☐
Itching	☐	☐
Lumps	☐	☐
Dryness	☐	☐
Color change	☐	☐
Hair or nail changes	☐	☐
MediPort/PICC line	☐	☐

Neurological	**No**	**Yes**
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Headaches	☐	☐
Arm or leg weakness	☐	☐
Difficulty moving your limbs	☐	☐

If yes: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

Numbness	☐	☐
Tremors	☐	☐

What is your learning preference:

☐ Written ☐ Verbal ☐ Video

Do you have any barriers to learning?	☐	☐

If yes; please specify: _____

Psychiatric/Emotional	**No**	**Yes**
Depression	☐	☐
Anxiety	☐	☐
Stress	☐	☐
Nervousness	☐	☐
Memory loss	☐	☐

Any thoughts of harming yourself/others?	☐ No	☐ Yes
Any specific plan of harming yourself/others?	☐ No	☐ Yes
Have you ever tried to harm yourself/others?	☐ No	☐ Yes
Are you having any difficulty coping?	☐ No	☐ Yes

Endocrine	**No**	**Yes**
Heat or cold intolerance	☐	☐
Increased perspiration	☐	☐
Frequent urination	☐	☐
Frequent thirst	☐	☐
Hematologic/Lymphatic	**No**	**Yes**
Ease of bruising	☐	☐
Ease of bleeding	☐	☐
Lumps in the neck/underarm/groin	☐	☐

Activity/Performance Status

Please check the description that best describe your performance level:

- ☐ Fully active, able to carry on all activities without restrictions
- ☐ Restricted in physically strenuous activity but ambulatory and able to carry out light work
- ☐ Ambulatory and capable of self-care but unable to carry out any work activities
- ☐ Capable of limited self-care, confined to bed or chair more than 50% of waking hours
- ☐ Completely disabled, cannot carry on any self-care, totally confined to bed or chair

PAIN:

Do you have any pain? ☐ No ☐ Yes

If yes:

Where is the pain? _____

How long does the pain last? _____

On a scale of 0 to 10, with 0 being no pain and 10 being worst pain you can imagine;

How much does it hurt right now?

Best level ____ Acceptable level ____ Worst level ____

What makes the pain better? _____

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

Are you taking any medication for the pain? ☐ No ☐ Yes

If yes; what? _____

How effective is it in treating your pain? _____

ADVANCED DIRECTIVES:

Please check all that apply:

- ☐ Living Will
- ☐ Do Not Resuscitate (DNR)
- ☐ Healthcare Proxy

Name and phone number of Healthcare Proxy:

_____

If any are checked, please bring a copy with you to your consultation appointment.

PHARMACY

Which Pharmacy do you use? _____

Address: _____

Telephone Number: _____

Signature: _____ Date: _____

If not signed by the patient, please print full name and relationship to patient:

Name: _____ Relationship: _____

Nursing Review by: _____ Date: _____