SAINT PETER'S UNIVERSITY HOSPITAL
Treating you better...for life.

Patient ID Label

MEDICAL HISTORY QUESTIONNAIRE
SAINT PETER'S UNIVERSITY HOSPITAL
DEPARTMENT OF RADIATION ONCOLOGY

Consultation Date: ________________

Radiation Oncologist: _________________________

Name: _____________________________ Birth date: ________________ Age: ______

Phone Number: Home: _________________ Cell: _________________ Work: _________________

REQUIRED:
Referring Physician: _________________________________ **Tel:** ________________________
Fax: ________________________

Primary Physician: _________________________________ **Tel:** ________________________
Fax: ________________________

Pharmacy:____

Address: ____ **Tel:** ________________________

Other Physicians involved in your care: ____

Diagnosis: What brings you here today? ____
____
____
____
____

PAIN: Yes No
Location: _________________ Does the pain Move? ___________________ Intensity 0-10 _______
Quality: ____
What has been helpful for pain in the past?____
What has not been helpful?____
Have you ever had this problem before? ________ If so, did you have any treatment for it?__________

MEDICAL HISTORY
Do you have or have you ever had a history of (check off)

☐ Heart Disease
☐ High Blood Pressure
☐ Stroke
☐ Kidney Problems
☐ Diabetes
☐ Lung Disease
☐ Asthma
☐ Gastrointestinal

☐ Arthritis
☐ Seizures
☐ Thyroid
☐ Glaucoma
☐ Autoimmune
☐ Mental Illness
☐ Cancer
☐ Elevated Cholesterol
☐ Pacemaker Defibrillator

Vaccinations up to date: Yes___ No___
Flu Shot _______________
Pneumonia Shot ________________
Zoster (shingles) Shot ____________
Colonoscopy _________________
Other __________________________

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Have you had chemotherapy? Yes___ No___ If yes, what type?____
____

How many cycles? ______________________________ When was the last? _____________________________________

Have you ever had Radiation Therapy before? Yes No
Where? ____ When? ____
To what part of you body? ____

SURGICAL HISTORY
List all operations and/or biopsies that you have had.
____
____
____
____

SOCIAL HISTORY *(circle one)*

Married Divorced Widowed Single Separated

Children: Yes No How many? _________________

Where do you live? ____

Do you work? Yes No

What type of work do you do? ____

Smoke: Yes No For how long? _______________________ How many packs per day? _________________

Smoking cessation material given: Yes No

Do you drink alcohol? Yes No How much? ____

Have you ever used recreational drugs? Yes No What types? _______________________________________

HIV status if known ____

Do you have an Advanced Directive? Yes No

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FAMILY HISTORY

What types of illnesses run in your family?

- ☐☐ Heart disease
- ☐☐ High blood pressure
- ☐☐ Stroke
- ☐☐ Kidney problems
- ☐☐ Diabetes
- ☐☐ Lung disease
- ☐☐ Asthma
- ☐☐ Autoimmune diseases, Lupus, Rheumatoid Arthritis, Scleroderma
- ☐ Emphysema
- ☐ Thyroid
- ☐☐ Autoimmune disease
- ☐☐ Arthritis
- ☐☐ Mental illness
- ☐☐ Gastrointestinal problems
- ☐☐ Ulcers, colitis, Crohns
- ☐☐ Cancer ____________________________

REVIEW OF SYSTEMS—Please check where applicable

Weight Changes? Yes ___ No ___

- ☐ Fevers
- ☐☐ Chills
- ☐☐ Night sweats
- ☐☐ Fatigue
- ☐☐ Itching
- ☐☐ None

HEAD, EARS, EYES, NOSE, THROAT

- ☐☐ Headaches
- ☐☐ Blurred Vision
- ☐☐ Double Vision
- ☐☐ Tearing
- ☐☐ Earaches
- ☐☐ Ringing in the ears
- ☐
- ☐ Bloody nose
- ☐ Runny nose
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ None

SKIN

- ☐☐ Skin irritation
- ☐☐ Rashes
- ☐☐ None

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RESPIRATORY/CARDIOVASCULAR

- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest discomfort, pain, tightness, pressure
- ☐ Palpitations
- ☐ Dizziness, lightheadedness, blackouts
- ☐ None

GASTROINTESTINAL

- ☐ How is your appetite? ____________________
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ None

GENITOURINARY

- ☐ Urgency, frequency, or hesitancy
- ☐ Dribbling
- ☐ Blood in the urine
- ☐ Inability to hold your urine
- ☐ Burning upon urination
- ☐ Are you up at night more than once to urinate?
- ☐ Back pain
- ☐ History of infection
- ☐ Kidney stones
- ☐ None

REPRODUCTIVE – MALE

- ☐ Prostate problems
- ☐ Penile sores
- ☐ Penile discharge
- ☐ Erectile dysfunction
- ☐ Hernias
- ☐ Testicular lumps
- ☐ Hormonal/Lupron/Casadex, etc.
- ☐ None

REPRODUCTIVE - FEMALE

- ☐ Age at first period ___________
- ☐ Last menstrual period ____________
- ☐ Periods regular/irregular
- ☐ Vaginal bleeding/discharge
- ☐ Vaginal/pelvic infections
- ☐ Pelvic pain
- ☐ Date of last pap smear ____________
- ☐ Breast Changes
  - ☐ Last Mammogram _______________
- ☐ Number of pregnancies __________
- ☐ Number of children ______________
- ☐ Breast Fed ___________
- ☐ Hormone/birth control use ________
- ☐ Bra/cup size _____________

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MUSCULOSKELETAL

☐ ☐ Pain
☐ ☐ Joint swelling
☐ ☐ Joint stiffness
☐ ☐ Warmness of joints
☐ ☐ None

HEMATOLOGIC/LYMPHATIC

☐ ☐ Bruising
☐ ☐ Bleeding anemia
☐ ☐ Past transfusions
☐ ☐ Swollen glands/lumps
☐ ☐ None

ENDOCRINE

☐ ☐ Heat/cold intolerance
☐ ☐ Excessive hunger/thirst
☐ ☐ Weight loss/gain
☐ ☐ Severe fatigue
☐ ☐ Inability to concentrate
☐ ☐ None

NEUROLOGICAL

☐ ☐ Weakness
☐ ☐ Loss of consciousness
☐ ☐ Fainting
☐ ☐ Seizures
☐ ☐ Numbness/tingling
☐ ☐ None

To be completed by nurse only:

Blood Pressure: ________________ Pulse:_________ Height:_________ Weight:_________ Temp:_________

ECOG/KPS: ____________________ Pulse Ox : ____________________ Respirations: ____________________

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MEDICATION LIST:
Please list all current medications, include prescriptions, over-the-counter, patches, inhalers, eye drops, vitamins, & herbals.

Drug	Dose	Frequency Taken	How Taken

ALLERGIES:

Medication/Food/Herbal	Reaction/Side Effects

Form filled out by: ☐ patient ☐ other ______________________________

___________________________________ Date: ________________ Time: ________________
Nurse's Signature

X-175