

Department of Radiation Oncology
MEDICAL HISTORY FORM

Patient Name: _____

MR#: _____ DOB: _____ Date: _____

RT#: _____

Marital Status: _____ Occupation: (former if retired) _____

Type of Industry: _____

Industry Street Address: _____

City: _____ State: _____ Zip Code: _____

MEDICAL HISTORY: Have you ever had or have any of the following?

YESNO

1. High Blood Pressure
2. High Cholesterol
3. Cataracts/Glaucoma/Tunnel Vision
4. Irregular Heart Beat/Arrhythmia
5. Heart Disease (Heart Attack, Angina, etc.)
6. Bronchitis
7. Asthma
8. Tuberculosis (TB)
9. Emphysema
10. Stomach Ulcer/Duodenal Ulcer
11. Hernia
12. Colitis
13. Arthritis

YESNO

14. Kidney/Urinary Tract Infection
15. Menstrual Bleeding Irregularity/Infections
16. Psychiatric Illness
17. Migraine/Frequent headaches
18. Seizures/Epilepsy
19. Swollen Glands/Lumps
20. Blood Clots in Legs
21. Diabetes
22. Thyroid Problems
23. Cancer (previous diagnosis or benign tumor)
24. Pneumonia
25. Hepatitis/Liver Trouble
26. Other Medical Illnesses (Please List below)

If you have checked YES to any of the above please explain: _____

1. Please list any medications you are taking. Include vitamins, supplements and other medications you use occasionally. (Use additional sheet if necessary)

| Name of Medication | Dosage | Frequency | Name of Medication | Dosage | Frequency |
|--------------------|--------|-----------|--------------------|--------|-----------|
| | | | | | |
| | | | | | |

2. Yes No Do you have any allergies to medications? (**Describe any reactions**) _____

YESNO Please answer each question.

3. Do you use alcohol? If yes, how often? _____

4. Do you use or have you ever used tobacco? If yes, how often? _____

5. Do you have visual, hearing, or other physical limitations? (Please explain)

6. Have you ever had surgery or been hospitalized? (Please explain)

7. Have you ever had previous radiation therapy and/or chemotherapy treatments? (Please explain)

8. Are you currently receiving chemotherapy or hormonal treatments? – Start Date? _____

9. Do you exercise? How often (daily, weekly, monthly)? _____

10. Do you need help with financial issues, such as health or disability insurances, income maintenance programs, paying for your prescriptions, home care and medical equipment, understanding short or long term care facilities, counseling for yourself or family members, or other social work services?

11. Are you interested in receiving information related to Spiritual Care Services available at University Hospital?

FAMILY STATE OF HEALTH HISTORY

| RELATIONSHIP | AGE | STATE OF HEALTH (GOOD, FAIR, POOR) | LIST ANY DISEASES | IF DECEASED, CAUSE OF DEATH AND AGE |
|--------------|-----|---------------------------------------|-------------------|--|
| Father | | | | |
| Mother | | | | |
| Siblings | | | | |
| Children | | | | |

SYSTEMS REVIEW

Are you currently experiencing any of the following symptoms: (Please Check **YES** or **NO**)

YESNO

Constitutional Symptoms:

- 1. Recent Weight Change
- 2. Fevers or Chills
- 3. Decreased Energy

Eyes:

- 4. Visual Difficulty
- 5. Wear Glasses or Contact Lenses

Ears, Nose, Mouth, Throat:

- 6. Difficulty Swallowing
- 7. Chronic Sinus Problems
- 8. Nose Bleeds

Cardiovascular:

- 9. Chest Pain
- 10. Heart Palpitations

Respiratory:

- 11. Shortness of Breath
- 12. Coughing/Wheezing/Hoarseness
- 13. Spitting up Blood

Gastrointestinal:

- 14. Bowel Problems
(Diarrhea, Constipation, etc.)
- 15. Rectal Bleeding
- 16. Abdominal Cramping

YESNO

Genitourinary:

- 17. Blood in Urine/Burning
- 18. Male - Testicle Pain
- 19. Female - Pain with or Irregular Periods

Integumentary:

- 20. Skin Problems (rashes, burning, bumps, color change)

Neurological:

- 21. Headaches
- 22. Fainting/Dizziness
- 23. Convulsions or Seizures

Hematologic/Lymphatic:

- 24. Easy Bruising or Bleeding
- 25. Past Transfusion

Psychiatric:

- 26. Anxiety/Depression
- 27. Memory Loss or Confusion

Endocrine:

- 28. Glandular or Hormone problem
- 29. Feel Hot or Cold

Musculoskeletal:

- 30. Unusual Aches or Pains (muscles or joints)
- 31. Weakness in Arms or Legs

If you checked "YES" to any of the above please explain or describe any other symptoms:

Does anyone in the family have a history of cancer or benign tumors? If yes, please explain.

I certify that the information completed on this form is true and complete to the best of my knowledge.

Signature of Patient or Guardian

Date

TO BE COMPLETED BY ATTENDING PHYSICIAN ONLY

I, the undersigned, have reviewed all contents of this completed form and have discussed all positive pertinent data with the patient:

Attending Physician Signature:

Printed Name

Date:

