COMPREHENSIVE CANCER CENTERS

Radiation Patient Questionnaire

Name: _____ Date of Consultation: _____

Problems that have led patient to seek medical attention here? _____

_____

_____

Please provide the names and phone numbers of your physicians (primary care, medical oncologist, surgeon, etc.)

_____

_____

Past Medical History

Chemotherapy: Have you ever had chemotherapy? If so, give date and place _____

_____

_____

Radiation Therapy: Have you ever had radiation therapy, radiation implants, cobalt treatment, etc.?

Yes No (if yes, please provide location, dates and phone numbers of center where you were treated) _____

_____

_____

Surgery: Please list all previous surgeries you've had and your approximate age at that time

_____

_____

_____

Accidents: Have you had any accidents or injuries of serious consequence? Yes No

Please list: _____

_____

Recent Hospitalizations: _____

Past Illness: Please check if you have history of, or currently have any of the following:

	Yes	No			Yes	No
Diabetes				Heart Trouble		
Kidney Disease				Phlebitis		
High Blood Pressure				Hepatitis B or C		
Bronchitis				HIV		
Seizures				Thyroid		
Tuberculosis				Back Pain		
Emphysema				Stomach Ulcers		
Liver Disease				Skin Disease		
Other						

Childhood Disease: _____

Current Medication (please list): _____

_____

Medication Allergies (please list): _____

_____

Family History:

	Alive	Current Age Age at Death	Cause of Death	List Any Cancer	Other Significant Medical Problems
Father	Yes No				
Mother	Yes No				

Please list any other family members who have had cancer:

Breast Cancer	Who _____	Other _____
Ovarian Cancer	Who _____	Other _____
Colon Cancer	Who _____	Other _____
Prostate Cancer	Who _____	Other _____

Social History:

Are you currently: employed retired unemployed on disability

Occupation: (current or former) _____

Marital Status: single married divorced widowed separated

Current living situation: (circle all that apply) alone with spouse significant other friend parent child other relative

Children: # males _____ Ages _____ # females _____ Ages _____

Have you ever smoked? Yes No If yes, your age when you started _____ Average packs per day _____ date quit (if applicable) _____.

Do you drink alcohol? Yes No What type _____ How much per week _____

Did you ever drink large amounts of alcohol Yes No Date quit (if applicable) _____

Review of Systems:

Do you currently suffer form ay of the following:

General

Fevers	Yes	No		Hearing Loss	Yes	No
Night Sweats	Yes	No		Nose Bleeds	Yes	No
Poor Appetite	Yes	No		Dry Mouth	Yes	No
Weight Loss How many pounds?	Yes	No		Hoarse Voice	Yes	No
				Cataracts	Yes	No
				Glaucoma	Yes	No

Cardiovascular System

Chest pain with effort	Yes	No		Heart Murmur	Yes	No
Palpitations	Yes	No		Ankle Swelling	Yes	No
				Pacemaker or implanted defibrillator	Yes	No

Pulmonary System

Cough	Yes	No		Shortness of Breath	Yes	No
Coughing Blood	Yes	No		Pain with Breathing	Yes	No

Review of Systems (continued):

Gastrointestinal System

Nausea	Yes	No		Yellow Skin (jaundice)	Yes	No
Vomiting	Yes	No		Clay Colored Stool	Yes	No
Constipation	Yes	No		Blood in the Stool	Yes	No
Diarrhea	Yes	No		Abdominal Pain	Yes	No
Have you ever had a colonoscopy?				If yes, when?		

Nervous System

Headaches	Yes	No		Tremors	Yes	No
Dizziness	Yes	No		History of Stroke	Yes	No
Paralysis	Yes	No		History of Seizure	Yes	No
Weakness of an arm or leg	Yes	No		Speech Disturbance	Yes	No
Loss of Sensation	Yes	No		Mental Illness	Yes	No

Musculoskeletal System

Arthritis	Yes	No		Limited Motions	Yes	No
Back Pain	Yes	No		Muscle Cramps	Yes	No

Hematologic

History of blood transfusions?	Yes	No		Treatment for anemia?	Yes	No
Any history of abnormal bleeding (i.e. with surgeries or dental work?)					Yes	No

Genitourinary System

Pain with Urination	Yes	No		Urgent Urination	Yes	No
Blood in the Urine	Yes	No		Incontinence	Yes	No
Frequent Urination	Yes	No		Retention of Urine	Yes	No

How many times per night do you wake up from sleep to urinate? _____

(For Men Only)

Do you have impotence? Yes No Partial Total

(For Women Only)

Date of last menstrual period _____. Date of last mammogram _____.

Age at menopause _____.

Number of pregnancies _____. Number of deliveries _____.

Age at first pregnancy _____. History of c-sections _____.

Hormonal Therapy Yes No Previous Current

Are you currently pregnant? Yes No Unsure

Could you possibly be pregnancy? Explain _____

COMPREHENSIVE CANCER CENTERS

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES FOR NEVADA

ATTENTION: If you speak any of the following languages, language assistance services, free of charge, are available to you. Call 1-877-261-6608 for more information.

Amharic:	**Arabic**
: 1-877-261-6608	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن 1-877-261-6608 رقم) اتصل برقم .خدمات المساعدة اللغوية تتوافر لك بالمجان :هاتف الصم والبكم 1-877-261-6608).
Chinese:	**French:**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-261-6608。	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-261-6608.
German:	**Ilocano:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-261-6608.	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-877-261-6608.
Japanese:	**Korean:**
تت. ! 1-877-261-6608 !	*주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.* 1-877-261-6608
Russian:	**Samoan:**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-261-6608.	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-877-261-6608.
Spanish:	**Tagalog:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-261-6608.	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-261-6608.
Thai:	**Urdu:**
□ 4□□ 0□ 8□ □ 1-877-261-6608	ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-261-6608
Vietnamese:	
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-261-6608.	