Radiation Oncology Services

Charleston Area Medical Center

A department of CAMC in partnership with Akumin

PATIENT INFORMATION

Patient Name	
Date of Birth	MRN#

Past Medical History: Please list previous medical problems such as heart disease, diabetes, stroke, high blood pressure, asthma, bronchitis, emphysema, etc.

Past Surgical History: Please list previous surgeries with dates.

Personal/Social History:

Alcohol: ☐ Yes ☐ No If yes, how many per day _____ or week _____

Tobacco: ☐ Yes ☐ No If yes, how many per day _____ or week _____

How many years have you smoked? _____

If you quit smoking, when did you quit? _____

Occupation _____

Family History of Cancer: Who / What type of cancer / Age at diagnosis? *Example: (mother / breast cancer / age 60)*

Do you have a pacemaker/defibrillator? ☐ Yes ☐ No

Have you ever had radiation therapy or cobalt therapy in the past? ☐ Yes ☐ No

If yes, when in the past? _____

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Have you ever had chemotherapy? ☐ Yes ☐ No

If yes, which drugs? _____

Do you have an autoimmune disease (Rheumatoid, Lupus, etc)? ☐ Yes ☐ No

Do you have any infectious disease (Tuberculosis, HIV, Hepatitis, etc)? ☐ Yes ☐ No

Have you ever had x-ray treatment to your neck, thyroid, or tonsils? ☐ Yes ☐ No

If yes, which one? _____ When? _____

PAIN SCORE

On a scale of 0 – 10 *(0= no pain, 10 = severe, worst pain ever)*, what is your pain today?

Circle One:

None		Mild		Moderate			Severe			Worst ever
0	1	2	3	4	5	6	7	8	9	10

Allergies: Please list all medical allergies.

_____

_____

_____

Are you allergic to IV Contrast Dye? ☐ Yes ☐ No

Medications: Please list all medications you are currently taking or attach a separate list.

_____

_____

Preferred Pharmacy _____ Location _____

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FEMALES PATIENTS ONLY

PREGNANCY SCREENING

******It is very important for your radiation physician to be aware if you are or if there is a possibility you could be pregnant before or during your radiation therapy.***

For all females of reproductive age (post menarche to menopause e.g. ages 12-55)

Month _____ Day _____ Year _____ Do you currently practice any form of birth control? ☐ Yes ☐ No

I have / have not (check one) had surgery that will prevent pregnancy. ☐ Have ☐ Have not

If surgery:

Type _____ Date _____

I understand that women who are pregnant should be counseled regarding risks to the fetus/baby from exposure to radiation and those women of childbearing potential should have a pregnancy test before commencing radiation treatments if there is any chance that you may be pregnant.

To the best of your knowledge, are you pregnant (or is there any chance you could be)? ☐ Yes ☐ No ☐ Possibly

Patient/Guardian Signature _____ Date _____

FOR OFFICE USE ONLY:

Pregnancy Test required (per department guideline)? ☐ Yes ☐ No			
If yes	Consent to test from: ☐ Patient ☐ Guardian		
Date test performed:		Type of Test:	
Results: ☐ Negative ☐ Positive			

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ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

General		
Good General Health Lately	☐ No	☐ Yes
Recent Weight Change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Eyes and Vision		
Eye Disease or Injury	☐ No	☐ Yes
Wear Glasses or Contact Lenses	☐ No	☐ Yes
Blurred or Double Vision	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Ears, Nose, Throat		
Hearing Loss	☐ No	☐ Yes
Ringing In the Ears	☐ No	☐ Yes
Earaches or Drainage	☐ No	☐ Yes
Sinus Problems	☐ No	☐ Yes
Nose Bleeds	☐ No	☐ Yes
Mouth Sores	☐ No	☐ Yes
Bleeding Gums	☐ No	☐ Yes
Bad Breath or Bad Taste	☐ No	☐ Yes
Sore Throat or Voice Change	☐ No	☐ Yes
Swollen Glands in Neck	☐ No	☐ Yes
Heart and Cardiovascular		
Heart Trouble	☐ No	☐ Yes
Chest Pains	☐ No	☐ Yes
Sudden Heartbeat Changes	☐ No	☐ Yes
Swelling of Feet, Ankles, Hands	☐ No	☐ Yes
Respiratory		
Frequent Coughing	☐ No	☐ Yes
Spitting Up Blood	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes
Asthma or Wheezing	☐ No	☐ Yes
Gastrointestinal		
Loss of Appetite	☐ No	☐ Yes
Change in Bowel Movements	☐ No	☐ Yes
Nausea or Vomiting	☐ No	☐ Yes
Frequent Diarrhea	☐ No	☐ Yes
Painful Bowel Movement/Constipation	☐ No	☐ Yes
Blood In Stool	☐ No	☐ Yes
Stomach Pain	☐ No	☐ Yes
Hematologic/Lymphatic		
Slow To Heal After Cuts	☐ No	☐ Yes
Easily Bruise or Bleed	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Transfusion	☐ No	☐ Yes
Swollen Glands	☐ No	☐ Yes

Musculoskeletal		
Joint Pain	☐ No	☐ Yes
Joint Stiffness or Swelling	☐ No	☐ Yes
Weakness of Muscles/Joints	☐ No	☐ Yes
Muscle Pain or Cramps	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes
Cold Extremities	☐ No	☐ Yes
Difficulty in Walking	☐ No	☐ Yes
Skin and Breasts		
Rash or Itching	☐ No	☐ Yes
Change in Skin Color	☐ No	☐ Yes
Change In Hair or Nails	☐ No	☐ Yes
Varicose Veins	☐ No	☐ Yes
Breast Pain	☐ No	☐ Yes
Breast Lump	☐ No	☐ Yes
Breast Discharge	☐ No	☐ Yes
Neurological		
Frequent or Recurrent Headaches	☐ No	☐ Yes
Light Headed Dizzy	☐ No	☐ Yes
Convulsions or Seizures	☐ No	☐ Yes
Numbness or Tingling Sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Head Injury	☐ No	☐ Yes
Psychiatric		
Memory Loss or Confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Sleep Problems	☐ No	☐ Yes
Endocrine		
Glandular or Hormone Problem	☐ No	☐ Yes
Thyroid Disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Excessive Thirst or Urination	☐ No	☐ Yes
Heat or Cold Intolerance	☐ No	☐ Yes
Dry Skin	☐ No	☐ Yes
Change in Hat or Glove Size	☐ No	☐ Yes
Genitourinary		
Frequent Urination	☐ No	☐ Yes
Burning or Painful Urination	☐ No	☐ Yes
Blood in Urine	☐ No	☐ Yes
Change in Force or Strain W/Urination	☐ No	☐ Yes
Incontinence or Dribbling	☐ No	☐ Yes
Kidney Stones	☐ No	☐ Yes
Sexual Difficulty	☐ No	☐ Yes
Painful or Irregular Periods	☐ No	☐ Yes
Vaginal Discharge	☐ No	☐ Yes

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