Princeton Radiation Oncology

Patient Name: ____ Today's Date: __________________

It is important that the physician be made aware of all of your health issues/concerns. Please check either ***No*** or ***Yes*** if you have experienced any of the health condition listed below over the past month.

	Health Condition	**No**	**Yes**	**Do not write in this section**
Constitutional	Fatigue			
	Fever			
	Night sweats			
	Weight loss			
	Weight gain			
Skin	Rashes			
	Itching			
	New or changed mole			
	Unhealed sores			
Head, Ears, Eyes, Nose and Throat (HEENT)	Visual changes			
	Hearing changes			
	Nose bleeds			
	Ear pain			
	Change in voice			
	Difficulty swallowing			
	Pain with swallowing			
Cardiac	Chest pain			
	Palpitations			
	Dizziness or fainting			
Pulmonary	Shortness of breath at rest			
	Shortness of breath climbing stairs			
	Cough			
	Coughing up blood			
Gastrointestinal	Loss of appetite			
	Indigestion/heartburn			
	Bloating			
	Nausea/vomiting			
	Diarrhea			
	Constipation			
	Rectal bleeding			
	Incontinence			
	Date of last colonoscopy: ___________________________			
Genitourinary	Frequent urination			
	Urgency with urination			
	Burning with urination			
	Blood in Urine			
	Incontinence			

	Health Condition	No	Yes	Do not write in this section
Musculoskeletal	Muscle or joint pains			
	Joint swelling			
Neurological	Headaches			
	Memory loss/confusion			
	Numbness/tingling			
	Muscle weakness			
	Unsteady when walking			
Psychiatric	Anxiety			
	Depression			
Endocrine	Excessive thirst			
	Excessive urination			
	Intolerance to heat or cold			
Hematologic	Easy bleeding/bruising			
	Frequent infections			

Do you have a pacemaker? ☐ No ☐ Yes

Do you have an implanted defibrillator? ☐ No ☐ Yes

Do you have any auto immune diseases? ☐ No ☐ Yes

Any family members had cancer? ☐ No ☐ Yes

If yes, who? ____

Do you smoke? ☐ Never ☐ Currently ☐ In the past? What year did you stop smoking? _______

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week? ___________

FOR WOMEN ONLY

	Health Condition	No	Yes	Do not write in this section
Breast	Lumps			
	Nipple discharge			
	Date of last mammogram: ___________________________			
Gynecologic	Abnormal bleeding			
	Last menstrual cycle: _______________________________			
	Number of pregnancies: _____________________________			
	Number of birth: __________________________________			
	Last PAP smear: ___________________________________			

____ _____________________

Patient Signature Date

____ ___________________

Signature of person completing form (if other than patient) Relationship to patient