

Long Island Radiation Therapy

Health History

Patient Name _____ Date _____

Using a check mark (✓) please indicate if you have ever had any of the below:

	<u>No</u>	<u>Yes</u>	
Previous Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cardiovascular</u>			
	<u>No</u>	<u>Yes</u>	
1. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Endocrine</u>			
	<u>No</u>	<u>Yes</u>	
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Gastrointestinal Problems</u>			
	<u>No</u>	<u>Yes</u>	
6. Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Colitis / Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Inflammatory Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Neurological</u>			
	<u>No</u>	<u>Yes</u>	
14. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Respiratory / Pulmonary</u>			
	<u>No</u>	<u>Yes</u>	
18. Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Urinary/Genito Problems</u>			
	<u>No</u>	<u>Yes</u>	
22. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Burning urgency	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Increased urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Decreased interest in sex	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Impotence	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Vaginal pain / dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Other</u>			
	<u>No</u>	<u>Yes</u>	
29. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
30. Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
31. Notable weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
32. Lupus, rheumatoid, scleroderma arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____

If "yes", please explain when/where if applicable.

Long Island Radiation Therapy

Health History

Pain

Do you have pain? No Yes *Where?* _____

Past Surgery

Please list any surgery you have had. List **type** of surgery, **date** of surgery and **surgeon's name**.

Operation	Date	Name of Surgeon
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

Medications

Please list prescribed **medications** you take "**daily**" including **vitamins** and **non-prescription** medications. Include dosage and frequency.

Name of Medicine	Dosage	How many times per day?
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____

Do you have any allergies to medication? No Yes

If yes, what medication are you allergic to? _____

What kind of reaction did you have? _____

Family History

Has anyone in your family had cancer? No Yes

If "**yes**", who and what type of cancer? _____

Social History

Married Single Widowed Divorced Separated

Occupation _____

1. Do you or did you smoke tobacco? No Yes # of packs per day _____ #years _____ Quit

2. Do you or did you drink alcohol regularly? No Yes *social moderate (1-2/day)* *heavy (3or>/day)* Quit

Women Only:

Menstrual periods: Age of onset _____ Age of menopause _____

Pregnancies: # of pregnancies _____ # of children alive _____

Age at first live birth _____

Have you ever used birth control pills? No Yes When & how long? _____

Have you ever been on hormone replacement therapy? No Yes Why? _____

Do you have a history of breast cysts or breast biopsy? No Yes

Did you breastfeed? No Yes

Please feel free to include any other data that will aid us in treating you on a daily basis.

Please list the names of doctors who take care of you so that we can send them a report.

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Reviewed by: _____, M.D. Date _____