

LONG ISLAND RADIATION THERAPY

JB AV JP DE DC

Consult Date_____

Submit Date_____

PATIENT NAME_____ DOB_____ Acct.#_____

MAIDEN NAME_____ SS# _____ - _____ - _____

When you were first diagnosed, what was your marital status? Single Married
 Divorced Widowed Separated

When you were first diagnosed, what was your address:

Street address_____

City, State, Zip_____

Telephone_____ County_____

RACE: (excluding Spanish / Hispanic): (please check one)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Black | <input type="checkbox"/> Laotian | <input type="checkbox"/> Melanesian |
| <input type="checkbox"/> American Indian, Aleutian or Eskimo | <input type="checkbox"/> Hmong | <input type="checkbox"/> Fiji Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Kampuchean | <input type="checkbox"/> New Guinean |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Thai | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Micronesian | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Chamorran | <input type="checkbox"/> Other |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Asian Indian, Pakistani | <input type="checkbox"/> Polynesian | |
| <input type="checkbox"/> Tahitian | <input type="checkbox"/> Samoan | |

SPANISH / HISPANIC ORIGIN: (please check one)

- | | |
|---|--|
| <input type="checkbox"/> Non Spanish | <input type="checkbox"/> Cuban |
| <input type="checkbox"/> Mexican (includes Chicano) | <input type="checkbox"/> South or Central America |
| <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Other specified Spanish / Hispanic origin (includes European) |

Where were you born? (State or Country) _____

What is/was your usual occupation? _____

TOBACCO HISTORY:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Never used | <input type="checkbox"/> Combination use, current | <input type="checkbox"/> Cigar / Pipe smoker, current |
| <input type="checkbox"/> Previous use | <input type="checkbox"/> Chew / Smokeless, current | <input type="checkbox"/> Cigarette smoker, current |

DATE OF PRIMARY DIAGNOSIS:_____

PLACE OF DIAGNOSIS (county):_____

AGE AT DIAGNOSIS _____