

Long Island Radiation Therapy

Health History

Patient Name _____ Date _____

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

	No	Yes	If "yes", please explain.
Previous Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Urinary Problems

a) Urgency	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____

Gastrointestinal Problems

a) Inflammatory Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
f) Colitis / Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other

a) Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____

Lupus, Scleroderma, Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain of Any Kind	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent Pain of Any Kind	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other _____

Do you or did you smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or did you drink alcohol regularly?	<input type="checkbox"/>	<input type="checkbox"/>	

