TACOMA VALLEY
RADIATION ONCOLOGY CENTERS
HEALTH | HEALING | HOPE
www.Defeatyourcancer.com

HEALTH QUESTIONNAIRE

Patient Name:	Date of Birth:	Age:
Please provide us with the names of your Physicians:		
Referring Physician:		
Family Physician:		
Medical Oncologist:		
Surgeon:		
Dentist:		
I have Dental Insurance ❒ Yes ❒ No		
Permission to discuss your diagnosis with family members? ❒ Yes ❒ No	*If you need special considerations as to the gender of your doctor please share your reasons with your physician or nurse and we will do our best to meet your need.*	

MEDICATIONS *List all current medications and doses and any herbs, supplements or vitamins* ❒ None

Medication/Supplement	How much do you take?	How often do you take it?

ALLERGIES *List all allergies and reactions.* ❒ None

Allergy	Reaction

Patient Name _____

OTHER MEDICAL CONDITIONS *check all that apply to you.* ❒ None

❒ High Blood Pressure (Hypertension)	❒ Fibromyalgia
❒ High Cholesterol (Hypercholesterolemia)	❒ Eczema
❒ Arthritis	❒ Diabetes Type 1
❒ Coronary Heart Disease	❒ Anxiety
❒ Diabetes Type 2	❒ Asthma
❒ Chronic Kidney Disease	Other: *please list below*
❒ Heart Failure	❒
❒ Depression	❒
❒ Alzheimer's Disease	❒
❒ Dementia	❒
❒ COPD	❒

PAST SURGERIES *List any surgeries and year performed.* ❒ None

Past Surgery	Year	Where

LAST CHEMOTHERAPY TREATMENT DATE: _____

❒ I did not have chemotherapy

FAMILY HISTORY of CANCER

Immediate		Type of Cancer
Mother	❒ Yes	
Father	❒ Yes	
Sister	❒ Yes	
Brother	❒ Yes	
Child	❒ Yes	

Paternal		Type of Cancer
Grandmother	❒ Yes	
Grandfather	❒ Yes	
Aunt	❒ Yes	
Uncle	❒ Yes	

Maternal		Type of Cancer
Grandmother	❒ Yes	
Grandfather	❒ Yes	
Aunt	❒ Yes	
Uncle	❒ Yes	

GYNECOLOGICAL HISTORY

_____ Age at menarche (first menstrual cycle)
Date of most recent menstrual period:_____
_____ Age of first pregnancy _____ # of pregnancies _____ # of live births
_____ Age at Menopause
Have you used hormone replacement therapy? Yes No If yes, how long?_____
When did you discontinue hormone therapy?_____

Patient Name _____

REVIEW OF SYSTEMS: Please √ any of the items that apply to you or that you may be experiencing.

GENERAL
- ❒ Fatigue
- ❒ Fevers
- ❒ Chills

Normal Weight: _____
- ❒ Recent weight loss
  Amount:_____
- ❒ Recent weight gain
  Amount: _____
- ❒ Difficulty sleeping

EYES
- ❒ Blindness
- ❒ Blurred vision
- ❒ Eye pain

EARS/NOSE/THROAT
- ❒ Loss of hearing
- ❒ Ear ache
- ❒ Ringing in ears-Tinnitus
- ❒ Nose bleed
- ❒ Dentures
- ❒ Bleeding gums
- ❒ Dry mouth
- ❒ Frequent sore throats
- ❒ Difficulty swallowing
- ❒ Hoarseness
- ❒ Loss of taste
- ❒ Neck stiffness
- ❒ Neck pain or swelling

RESPIRATORY
- ❒ Coughing
- ❒ Coughing up sputum
- ❒ Coughing up blood-Hemoptysis
- ❒ Wheezing
- ❒ Shortness of breath-dyspnea
- ❒ Decreased exercise tolerance
- ❒ Shortness of breath with exertion
- ❒ Oxygen use at home

How many Liters:_____

CARDIOVASCULAR
- ❒ Palpitations
- ❒ Heart murmur
- ❒ Chest pain
- ❒ Leg swelling
- ❒ Pacemaker
- ❒ Defibrillator

BREASTS

Left side:	**Right side:**
❒ Nipple inversion	❒ Nipple inversion
❒ Lump or mass	❒ Lump or mass
❒ Pain in breast	❒ Pain in breast
❒ Nipple discharge	❒ Nipple discharge
❒ Breast redness	❒ Breast redness
❒ Breast swelling	❒ Breast swelling
❒ Color changes	❒ Color changes
❒ Axilla tenderness	❒ Axilla tenderness
❒ Axilla numbness	❒ Axilla numbness

GASTROINTESTINAL
- ❒ Heartburn
- ❒ Inflammatory Bowel Disease
- ❒ Nausea
- ❒ Abdominal pain/cramping
- ❒ Vomiting
- ❒ Diarrhea
- ❒ Constipation
- ❒ Blood in stool-Melena
- ❒ Hemorrhoids/fissures

GENITOURINARY
- ❒ Pain & burning with urination-dysuria
  ❒mild ❒ moderate ❒ severe
- ❒ Frequent urination:
  ❒mild ❒moderate ❒Severe
- ❒ Up at night to pass urine
  How Many Times:_____
- ❒ Blood in urine-Hematuria
- ❒ Urgency
- ❒ Weak stream
- ❒ Sexual difficulties

WOMEN ONLY - - - - - - - - - - - - - - - -
- ❒ Vaginal yeast infections
- ❒ Vaginal discharge
- ❒ Heavy bleeding
- ❒ Thrush
- ❒ Painful intercourse-dyspareunia
- ❒ Hot flashes

MEN ONLY- - - - - - - - - - - - - - - - - -
- ❒ Impotence
- ❒ Difficulty with erections
- ❒ Penile discharge
- ❒ Testicular mass
- ❒ Testicular pain

MUSCULOSKELETAL
- ❒ Weakness
- ❒ Decreased range of motion
- ❒ Muscle aches/pains
- ❒ Joint swelling

NEUROLOGICAL
- ❒ Headaches
- ❒ Confusion
- ❒ Short term memory loss
- ❒ Long term memory loss
- ❒ Seizures
- ❒ Numbness or tingling
- ❒ Dizziness
- ❒ Loss of coordination
- ❒ Unsteady gait

SKIN
- ❒ History of skin cancer
- ❒ Rash
- ❒ Skin color changes

ENDOCRINE
- ❒ Appetite changes
- ❒ Cold intolerance
- ❒ Increased thirst
- ❒ Hair changes

PSYCHIATRIC
- ❒ Anxiety
- ❒ Depression
- ❒ Distress

Rate your distress 0-10: _____

List your largest cause of distress:_____
_____

Patient Name _____

PAIN

Do you have pain? ❒ No ❒ Yes

If yes, where? _____

Please rate your current pain on a scale of 0-10. 0 = BEST or no pain. 10 = WORST or intolerable.

0	1	2	3	4	5	6	7	8	9	10

Does medication relieve pain? ❒ Yes ❒ No

When does your pain usually occur? _____

Comment:

DAILY HABITS

Nutrition

Are you on any special diet(s)? ❒ No ❒ Yes If yes, please describe?_____

Tobacco

Ever use tobacco? ❒ No ❒ Yes How many packs per day? _____

Currently use tobacco? ❒ No ❒ Yes What age started? _____

If yes, check type(s): What age stopped? _____

❒Cigarettes ❒Snuff ❒Pipe ❒Chew ❒Cigars ❒Other _____

Alcohol

Do you drink alcohol? ❒ No ❒ Yes If yes, how many drinks per day? _____

What age/year started? _____ If applicable, what age/year stopped? _____

Marijuana

Do you use Marijuana? ❒ No ❒ Yes If yes, how often? _____

Marital Status

❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Significant Other

❒ Living Together ❒ Available to assist _____

Social: Do you live with anyone else beside your partner?

❒ Children ❒ Parents ❒ Other:_____

❒ # of Children _____ ❒ Available to assist _____

Work History

Occupation:_____

Are you still working? ❒ Yes ❒ No

Were you exposed to carcinogenic substances, asbestos? ❒ No ❒ Yes List:_____

ADVANCE DIRECTIVE (Living Will) *We are required by WA state to inquire.*

Do you have an Advance Directive? ❒ Yes ❒ No

If yes, would you provide us with a copy for your medical record? ❒ Yes ❒ No

If you do not have an advance directive, would you like information? ❒ Yes ❒ No

I verify the above information is true and correct to the best of my belief.

Patient Signature _____ Date:_____

Reviewed by Physician_____ Date: _____