CANCER CENTER RADIATION ONCOLOGY

PATIENT HISTORY

To our patients:

Welcome to Hoag Cancer Center, Radiation Oncology Department. The information you provide using the enclosed form will be very helpful to us during your consultation today. Please fill out the form as completely and accurately as possible. We will review the form with you. We appreciate your assistance.

Sincerely,

Russell L. Hafer, M.D.
Craig A. Cox, M.D.
Peter Chen, M.D.
Brian Kim, M.D.
Radiation Oncology Nursing Staff

IF YOU ARE COMPLETING THIS FORM PRIOR TO YOUR ARRIVAL:

1. Bring your **insurance cards** with you. **.** We will copy your insurance cards and have you sign the outpatient consent form.

2. Please bring the **medications and vitamins** that you are currently taking, or an accurate list including dosage and frequency prescribed.

3. Please **arrive early** for your appointment. **Late arrivals may be rescheduled**

4. **Sign in** at the front desk.

5. **The first 30 minutes of your consultation** are for review of your history form and records. As part of our patient education process, you may also see a short video about radiation therapy.

6. You will then meet with the Radiation Oncologist.

Plan to be in our department for approximately 1-1/2 to 2 hours.

HOAG CANCER CENTER - RADIATION ONCOLOGY
INITIAL NURSING ASSESSMENT

PATIENT_________________________________ D.O.B_____________ Date______________

Occupation ______________________ Family Present _____________________

Diagnosis_______________________ Physician referred by:________________

Physicians____

VITAL SIGNS			
Temp:	Pulse:	Resp:	O2 Sat:
BP:	Height:	Weight:	Pain (0-10)______ Site_________ Describe:

HISTORY OF PRESENT ILLNESS

Chief complaint:

Prior radiation therapy? □No □Yes, Site treated_________________ Facility_____________________________

Prior records available? □No □Yes ____

Prior chemotherapy? □No □Yes, last treatment_________________ Facility_____________________________

____

Prior hormonal therapy? □No □Yes, last treatment Facility

ALLERGIES

List Medication/Reaction

PAST MEDICAL HISTORY(Please List All)

Major Medical Problems:

Prior Surgeries:

Family History of Cancer:

SOCIAL HISTORY/HABITS

Marital Status: (circle) Single Married Widow Single Separated Divorced

Lives with:___________________________________

	No	Yes
Fluent English	□	□
Primary Language: ___________________________		
Interpreter needed	□	□
Interpreter__________________________		
Insomnia	□	□
Difficult getting to sleep	□	□
Difficult maintaining sleep	□	□
Early AM awakening	□	□

	No	Yes
Alcohol use	□	□
How many drinks/Day _________________________		
Quit/When ______________	□	□
Treatment/Describe:		
Tobacco use?	□	□
How many years_________ pack/day__________		
Quit?	□	□
When: _________		
Assistance needed to abstain	□	□
Recreational drug use	□	□
Type:		

REVIEW OF SYSTEMS

CONSTITUTIONAL **No** **Yes** **No** **Yes**

Fatigue	☐	☐	Night Sweats	☐	☐	
Fatigue Level 1-5: ________			Weight loss	☐	☐	
KPS (RN to complete) ________			_____lb / _____months			
Fevers	☐	☐	Sudden weight gain	☐	☐	lbs______

EYES	**No**	**Yes**		**No**	**Yes**
Vision blurred	☐	☐	Glaucoma	☐	☐
Blind	☐	☐	Requires glasses	☐	☐
Cataracts	☐	☐	Requires contacts	☐	☐

EARS, NOSE, MOUTH, THROAT	**No**	**Yes**		**No**	**Yes**
Hearing Loss	☐	☐	Dentures/Partials	☐	☐
(circle) R / L / both sides			(circle) Upper / Lower / Both		
Hearing aid(s)	☐	☐	Dental problems	☐	☐
Hoarseness	☐	☐	Requires consult	☐	☐
Difficulty swallowing	☐	☐			

CARDIOVASCULAR/ RESPIRATORY	**No**	**Yes**		**No**	**Yes**
Heart Attack	☐	☐	Short of Breath	☐	☐
Stroke	☐	☐	Oxygen @ ____ L/min		
Angina	☐	☐	Unable to lie flat	☐	☐
Pace maker/ AICD	☐	☐	Sleep Apnea	☐	☐
High B/P	☐	☐	Coughing up blood	☐	☐
Cough	☐	☐	Emphysema/COPD	☐	☐
Asthma	☐	☐	Asbestos exposure	☐	☐

GASTROINTESTINAL	**No**	**Yes**		**No**	**Yes**
Nausea	☐	☐	Jaundice	☐	☐
Vomiting	☐	☐	Liver Disease	☐	☐
Constipation	☐	☐	Hiatal hernia	☐	☐
Diarrhea	☐	☐	Heartburn	☐	☐
Blood in stool	☐	☐	Ulcer	☐	☐
Hemorrhoids	☐	☐	Feeding tube	☐	☐
			# ___cans of ____________________/day		

GENITOURINARY	**No**	**Yes**	**Female:**	**No**	**Yes**	
Burning with urination	☐	☐	Vaginal itch/discharge	☐	☐	
Blood in urine	☐	☐	Describe:___________________			
Frequency	☐	☐	Hormone Replacement Therapy		☐ # of years _____	
Urgency	☐	☐	Last menstruation ________________			
Urinary incontinence	☐	☐	Menopause	☐	☐	Age_____
Male:			# of pregnancies: ____________			
Prostate problems	☐	☐	# of live births: ______________			
			Age @ first Pregnancy:_______			

INTEGUMENTARY	**No**	**Yes**		**No**	**Yes**
Rashes	☐	☐	Swelling	☐	☐
Location:___________________________			Location:___________________________		
Healing incisions	☐	☐	IV Access Device	☐	☐
Location:___________________________			Type:_________________		
Sores/Wounds	☐	☐			
Location:___________________________			History of Skin Cancer	☐	☐
New Mass(es)	☐	☐	Location:___________________________		
Location:_________________________			Type:		

REVIEW OF SYSTEMS (CONTINUED)

NEUROLOGICAL/ PSYCHIATRIC	No	Yes		No	Yes
Headaches	□	□	Confusion	□	□
Depression	□	□	Memory: □ Good	□ Fair	□ Poor
Seizures, freq:	□	□	Learning Preference:		
Dizziness	□	□	□ Written	□ Verbal	□ Video
Fainting	□	□	Barriers	□	□
Numbness	□	□	Specify:________________________________		
Tingling	□	□			
Location:					

ALLERGIC/ IMMUNOLOGIC	No	Yes		No	Yes
Autoimmune disorder	□	□	Allergies to Food:	□	□
Type:__________________________			Allergies to meds:	□	□
Seasonal allergies	□	□	Other:		

MUSCULOSKELETAL	No	Yes	**Movement of extremities**	Normal □
Arthritis	□	□	□ Decreased in R / L upper extremities	
Location: ________________________			□ Decreased in R / L lower extremities	
Fall Risk	□	□	**Activities of Daily Living**	□No limits
Balance Difficulty	□	□	□ Needs dressing assistance	
Assistive Device	□	□	□ Needs meal assistance	
Type ________________________			Weakness □ □	
			Generalized □ □	
			Site:	

ENDOCRINE	No	Yes	HEMATOLOGIC	No	Yes
Diabetes	□	□	Anemia	□	□
Insulin dependent	□	□	Frequent infection	□	□
For how long?______________________			Bleeds easily	□	□
Thyroid disorder	□	□			

PAIN

Area of Pain____

Cause of Pain ____

Quality (describe pain) ____

Does Pain Radiate (where) ____

Time of Onset ____

Intensity Level 0-10 ____

Please rate your pain using 1-10 scale: 0= no pain 10=worst pain

What relieves pain?

Patient has problems with: □Child care □Spiritual issues □Financial issues □Transportation

Specify:

Other:

Advance Directive Yes □ No □ Pamphlet given □ Copy Received □

Video Yes □ No □ n/a □

RN: ______________________ **Date:**__________