OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

RADIATION ONCOLOGY
ESTABLISHED PATIENT

PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Medication Allergies: _____

_____

What treatments have you had so far for your current cancer diagnosis? Please list facilities and doctors.

1. Surgery:

_____

_____

_____

2. Chemotherapy:

_____

_____

_____

3. Radiation:

	HOSPITAL/FACILITIES	DOCTOR	DATE	AREA OF BODY
1.				
2.				
3.				

Surgeries/Radiation Treatments in the Past (Even if Unrelated to Current Illness)

	HOSPITAL/FACILITIES	DOCTOR	DATE	AREA OF BODY
1.				
2.				
3.				

HEALTH REVIEW

Have you experienced any of the following within the last month? (Please check all that apply)

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Failing Vision
- ☐ Eye Pain
- ☐ Nasal Problems
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Chewing Problems
- ☐ Trouble Swallowing
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Persistent Cough
- ☐ Dry Cough
- ☐ Cough Up Phlegm
- ☐ Cough Up Blood
- ☐ Bloody Urine
- ☐ Infection
- ☐ Change in Weight
- ☐ Loss of Appetite
- ☐ Stomach Pain
- ☐ Nausea/Vomiting
- ☐ Vomiting Blood
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Incontinence
- ☐ Voiding Too Often
- ☐ Urinary Discharge
- ☐ Painful Voiding
- ☐ Trouble Sleeping
- ☐ Tired
- ☐ Weak
- ☐ Nervousness
- ☐ Depression
- ☐ Sexual Problems
- ☐ Skin Rash
- ☐ Joint Pain
- ☐ Numbness
- ☐ Arm or Leg Weakness
- ☐ Trouble with Balance
- ☐ History of Falls
- ☐ Lumps/Masses
- ☐ Tremors
- ☐ Seizures
- ☐ Night Sweats

PAIN ASSESSMENT

Pain Scale: Face Rating

0	2	4	6	8	10
No Pain	Mild Pain	Discomforting	Distressing	Intense	Excruciating

Using the pain scale above, what is an acceptable level of pain for you? _____

Have you been having pain in the **last month?** ☐ Yes ☐ No

Location of pain: _____

Describe your pain: _____

What are you doing/taking to control your pain? _____

Using the pain scale above, rate your pain: _____

Location of pain: _____

Describe your pain: _____

Have you ever experienced pain in the past? ☐ Yes ☐ No

Location: _____

Describe your pain: _____

Using the pain scale above, rate that pain: _____

What did you do/take to control that pain? _____

SOCIAL STATUS

Living Situation: ☐ Home ☐ Nursing Home ☐ Apartment ☐ Assisted Living ☐ Other

If you checked nursing home or assisted living above, give the name of the facilities: _____

_____

Living Arrangement: ☐ Alone ☐ With Spouse/Partner ☐ Other

Primary Care Giver: ☐ Self ☐ Spouse ☐ Child ☐ Relative ☐ Friend ☐ Paid Attendant ☐ Other

Is there anyone who can help with your care at home if needed? ☐ Yes ☐ No

Are others dependent on you? ☐ Yes ☐ No

Pharmacy Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PHYSICIANS INVOLVED IN YOUR CARE

Referring Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specialist Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specialist Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of person completing form: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____