SHORE RADIATION ONCOLOGY
NEW PATIENT QUESTIONNAIRE
PLEASE COMPLETE ALL PAGES

Shore Radiation Oncology

PATIENT IDENTIFICATION

Please check (X) the appropriate box(es) (□) and fill in the blank(s) as needed.

Patient Name:			Birth Date:	Today's Date:
Name of Person Completing Form:				
Please list all of your physicians:				
Name of Physician	Specialty	Telephone# / Fax #		
What is your diagnosis?			When were you diagnosed?	
At which hospital were you diagnosed?				
What is your understanding of why you are being seen today?				
Have you had any of the following?				
Surgery for this diagnosis	□No	□Yes	Where was it done?	
Radiation for this diagnosis	□No	□Yes	Where was it done?	
Drug treatment or chemotherapy for this diagnosis	□No	□Yes	Where was it done?	
CT scans	□No	□Yes	Where was it done?	
MRI scans	□No	□Yes	Where was it done?	
PET scans	□No	□Yes	Where was it done?	
Bone scans	□No	□Yes	Where was it done?	
Ultrasounds	□No	□Yes	Where was it done?	
Chest x-ray (in the past year)	□No	□Yes	Where was it done?	
Blood tests (in the past year)	□No	□Yes	Where was it done?	
Other:			Where was it done?	
PAST MEDICAL HISTORY				
Have you had radiation therapy before for any reason?	□No	□Yes	When?	Where?
Have you had any other cancers?	□No	□Yes	If so, please describe:	
Do you have any of the following conditions?			Do you have Pacemaker/Defibrillator?	□No □Yes
□No □Yes High blood pressure	□No	□Yes	Heart disease	
□No □Yes Emphysema/COPD	□No	□Yes	Kidney disease	
□No □Yes Diabetes	□No	□Yes	Thyroid problems	
□No □Yes Liver disease	□No	□Yes	Stomach disease (i.e. ulcers, reflux)	
□No □Yes Mental health conditions (including depression)				
□No □Yes Bowel disease (i.e. irritable bowel, colitis, Crohn's, diverticulosis)				
Other:				
OTHER SURGERIES				
Date of surgery	Type of surgery	Hospital where performed		

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ALLERGIES (include medications, latex, food, other)	□ No known allergies
ALLERGY TO:	DESCRIBE THE REACTION:

REVIEW OF SYMPTOMS (Check all that you have had in the past year)

General: □fever □weight loss □weight gain □always tired □night sweats □chills □hot flashes □no problems

Skin: □ rash □ moles or change in moles □ sores □ lumps □ dryness □ itching □ no problems

Eyes: □ blurred vision □ double vision □ red or watery eyes □no problems

ENT: □ hearing loss □ ringing in the ears □ frequent sinus infections □sore throat □ hoarseness
□ dental problems □ no problems

Respiratory: □ cough □ shortness of breath □ wheezing □ frequent colds □ no problems

Cardiovascular: □ chest pain □ skipped or extra heartbeat □ swelling in legs or feet □ no problems

GI: □nausea □ vomiting □ heartburn □ problem swallowing □constipation □ diarrhea
□ change in bowel habits □ no problems

GU: □ frequent urination □ urgency with urination □ weak stream, pain or burning with urination
□ waking at night to urinate □ impotence □ penile discharge □ vaginal discharge □no problems

Endocrine: □ too thirsty □ increased need to urinate □ increased appetite
□feeling unusually hot or cold □ no problems

Blood/Immune System: □ easy bruising or bleeding □ anemia □ frequent infections □ no problems

Musculoskeletal: □pain in muscles □pain in joints or bones □difficulty walking or standing □ no problems

Neurologic: □headaches □ dizzy spells □ numbness or tingling anywhere □ poor balance □ memory loss
□ visual changes □ weakness □ paralysis □ seizures □ falls □ no problems

Pain: Are you having pain at this time? □Yes □ No

In the past week, what has your highest pain score been? 0-10 (0-no pain, 5-moderatepain, 10-worst pain)

In the past week, what has your lowest pain score been? 0-10 (0-no pain, 5-moderate pain, 10-worst pain)

Where is your pain?

How often do you have the pain? □ Once in a while □Frequently □ Constant

Type of pain: □Aching □Burning □Crushing □Dull □ Sharp Other:

What makes the pain better? What makes the pain worse?

Nutritional: How is your appetite? □ Good □ Fair □ Poor If poor, for how long?

Nausea or vomiting over 3 days? □No □Yes

Are you on a special diet? □No □Yes If yes, what kind?

Have you lost 10 or more pounds in the last 30 days without trying? □ No □Yes

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Functional: Have you experienced any of the following problems recently?

Difficulty walking? □Yes □No Falling? □Yes □ No Memory problems? □Yes □ No

Difficulty understanding what is said to you? □Yes □No Difficulty speaking? □Yes □ No

Difficulty with activities of daily living: cooking cleaning, shopping, driving, dressing, or bathing? □Yes □ No

FAMILY HISTORY OF CANCER:

Tell us who, if anyone, in your family has had cancer. What type of cancer did they have?

SOCIAL HISTORY:

What type of work did/do you do? □Retired

Marital status: □ Single □ Married □ Divorced □ Widowed

With whom do you live? □ Live alone

How will you travel to the hospital?

Which of these activities can you do yourself? □ Cook □Clean □ Bathe □ Shop

Do you smoke? □ No □Yes If yes,#_____ packs per day for # _____ years

If you used to smoke, #_____packs per day for # _____ years. Quit date: / /

Do you drink alcohol? □ No □Yes If yes, □ beer □ wine □ spirits

Number of drinks/week _____ If you used to drink, when did you stop? / /

Do you use drugs to get high? □ No □Yes If yes, which drugs?

ABUSE ASSESSMENT:

Are you in a harmful physical or emotional relationship? □ No □Yes

If yes: □ Hit/kicked □ threatened □ Forced to have sex □ Have you been denied food, water, medication

Other:

Do you have a safe place to go when you leave today? □ No □ Yes

EDUCATIONAL ASSESSMENT:

Is English your primary language? □Yes □ No

If not, what language do you speak? Do you need an interpreter? □ Yes □ No

CONTACT INFORMATION:

Home phone number: Cell phone number:

Patient work number: May we call you at work? □ No □Yes

May we leave information about your appointment with family? □ No □Yes

On Answering Machine: □No □Yes

If we cannot reach you, whom should we call??

How are you related? Phone#:

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For patients with Mouth / Neck Cancers only: □ *N/A*
Do you see a dentist regularly? □ No □ Yes Name of dentist:
Telephone #: Last visit:
Do you have any special dental problems? □ No □ Yes Please describe:
Do you have dentures? □ No □ Yes Do you have partial plates? □ Yes □ No
HEALTH MAINTENANCE
Have you had a flu vaccine? □No □Yes When / /
Have you had a pneumonia vaccine? □No □Yes When / /
Have you had a sigmoidoscopy/colonoscopy? □No □Yes When / /
MALE HISTORY □N/A
Do you have regular prostate exams? □No □Yes Last exam: / /
Do you have regular PSA tests? □No □Yes Last exam: / /
Do you do regular testicular exams on yourself ?□No □Yes Last exam: / /
FEMALE HISTORY □N/A
Age that you started having periods? ..
Have you had a hysterectomy? □No □Yes Year: Why was this done?
Have you had your ovaries removed? □No □Yes Year:
Age at menopause: Date of last menstrual period:
Do/did you use oral contraceptives? □No □Yes How long?
Do/did you take hormone replacement therapy? □ No □Yes How long?
Number of pregnancies? Number of live births? Age at first full term pregnancy:
Could you be pregnant now? □ No □Yes
Do you have regular mammograms? □No □Yes Last exam: / /
Do you have regular PAP tests? □No □Yes Last exam: / /
Do you have regular breast exams by a doctor?□No □Yes Last exam: / /
Do you perform regular breast self-exams? □No □Yes Last exam: / /
ADVANCE DIRECTIVE
Do you have either type of these Advance Directives? □ Living Will □ Durable Power of Attorney
Date of Directive / /
Would you like for us to give you information on Advance Directives? □No □Yes
RN Signature: _____ Date: Time:_____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

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MEDICATION LIST

Shore Radiation Oncology

PLEASE FILL OUT ALL CURRENT MEDICATIONS/SUPPLEMENTS

PATIENT IDENTIFICATION

MEDICATION NAME:	DOSE & Frequency:	PRESCRIBER NAME:
(Example) Tylenol	*500mg 3 times/day*	*Dr. Miller*

RN Signature: _____ Date: Time: _____

SIGNATURE REQUIRED PRINTED NAME REQUIRED