Patient Name

DOB

MRN

Physician

FIN

Questionnaire
PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC

Name ______________________ Today's date ____________

How would you prefer us to address you? ______________________

Who completed this form: ☐ Self ☐ Spouse ☐ Other (specify) ______________

Explain, in your own words, what the purpose for your appointment is______________________

____

MEDICATIONS

List any prescription and non-prescription medications that you are currently taking. Include supplements, hormones, vitamins, herbs, alternative medications

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

ALLERGIES

Allergic reaction to?

Latex: ☐ No ☐ Yes

Adhesive tape: ☐ No ☐ Yes

IV contrast: ☐ No ☐ Yes

Environmental: ☐ No ☐ Yes

If yes to any of above, describe reaction ______________________

____

MEDICATION	DESCRIBE REACTION

LIST ALL PAST AND CURRENT MEDICAL CONDITIONS AND SURGERIES (Include approximate dates)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Have you ever received radiation therapy: ☐ No ☐ Yes (list date, site treated and location of treating facility)

____

Have you ever received chemotherapy: ☐ No ☐ Yes (list date, site treated and location of treating facility)

____

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OVER →

PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC *(CONTINUED)*

FAMILY HISTORY

If known, complete the following information about your blood relatives. For each person list age, age of death and any cancer diagnosis. For deceased, indicate cause of death. Do not include adoptive parents, siblings or children.

FAMILY MEMBER	AGE, IF LIVING	DIAGNOSIS OF CANCER TYPE (IF ANY)	AGE AT TIME OF DEATH	CAUSE OF DEATH
Father				
Mother				

Do you or any direct family members have Lupus, scleroderma or other auto-immune disorders? ☐ No ☐ Yes

If yes, explain ______

Is there any other information about your family that you would like us to know ______

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you live: ☐ Alone ☐ With spouse/family ☐ Other (describe) ______

Current living arrangement: ☐ House ☐ Apartment ☐ Nursing Home ☐ Other ______

Who do you rely on most for support/help ______

What is/was your occupation ______ Are you currently employed: ☐ No ☐ Yes

List your pharmacy (include phone number if known) ______

Do you have prescription coverage: ☐ No ☐ Yes

Have you ever made use of the following:

	AMOUNT/TYPE	FREQUENCY	LENGTH OF USE	IF STOPPED, WHEN	DO YOU WANT INFORMATION ABOUT CESSATION/STOPPING?
Alcohol					☐ No ☐ Yes ☐ Declined
Caffeine					☐ No ☐ Yes ☐ Declined
Tobacco					☐ No ☐ Yes ☐ Declined
Recreation/ Street drugs					☐ No ☐ Yes ☐ Declined

Do you have a living will or advanced directive: ☐ No ☐ Yes

Would like information about living wills or advanced directive: ☐ No ☐ Yes ☐ Declined

While you are at our facility, do you wish to have pastoral care: ☐ No ☐ Yes ______

CONSTITUTIONAL/GENERAL SYMPTOMS

Generally speaking, have you had difficulty performing your usual daily activities? ☐ No ☐ Yes

Have you felt fatigued? ☐ No ☐ Yes

Other ______

REVIEW OF SYSTEMS

PAIN

Have you had significant pain in the past? ☐ No ☐ Yes

If yes, location ______

Do you have pain now? ☐ No ☐ Yes

If yes, location ______

Pain Rating Score ______ 0=no pain 10=the worst pain you have ever had.

What helps to relieve the pain? ______

What makes the pain worse? ______

How does this pain affect you? ______

Do you feel your pain is being managed well? ☐ No ☐ Yes

If no, describe ______

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Patient Name
DOB
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Physician
FIN

PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC *(CONTINUED)*

Indicate whether you have experienced the following symptoms in recent months by checking "No" or "Yes"

	NO	YES	FOR HEALTH CARE TEAM USE ONLY
CENTRAL NERVOUS ☐ **No concerns**			
Head injury with episode of "black out"	☐	☐	
Memory loss	☐	☐	
New or different headaches or migraines	☐	☐	
New or different seizures	☐	☐	
Numbness, where ____	☐	☐	
Tingling sensation, where ____	☐	☐	
Weakness, where ____	☐	☐	
Other ____			
EYE ☐ **No concerns**			
Changes in your vision	☐	☐	
Do you wear glasses/contacts	☐	☐	
Excessive tearing	☐	☐	
Other ____			
EAR/NOSE/THROAT ☐ **No concerns**			
Ringing in the ear(s) ☐ Right ☐ Left ☐ Both	☐	☐	
Diminished hearing ☐ Right ☐ Left ☐ Both	☐	☐	
Change in voice quality	☐	☐	
Other ____			
CARDIOVASCULAR ☐ **No concerns**			
Chest pain	☐	☐	
Irregular heart beat, describe ____	☐	☐	
Pacemaker	☐	☐	
Exercise intolerance	☐	☐	
Pain in calf(s) when walking	☐	☐	
Other ____			
RESPIRATORY ☐ **No concerns**			
Cough	☐	☐	
Difficulty breathing	☐	☐	
Shortness of breath	☐	☐	
Recent upper respiratory infection	☐	☐	
Positive tuberculosis skin test	☐	☐	
Other ____			
MUSCULOSKELETAL ☐ **No concerns**			
Any limitations in moving your joint or limb(s), describe: ____	☐	☐	
NUTRITION/METABOLIC/ENDOCRINE ☐ **No concerns**			
Impaired chewing	☐	☐	
Poor intake for greater than one week	☐	☐	
Tube feedings	☐	☐	
Unintentional weight loss greater than 10 pounds	☐	☐	
Unintentional weight gain	☐	☐	
Other ____			

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PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC *(CONTINUED)* Page 4 of 4

Indicate whether you have experienced the following symptoms in recent months by checking "No" or "Yes"

	NO	YES	FOR HEALTH CARE TEAM USE ONLY
GASTROINTESTINAL ☐ **No concerns**			
Heartburn	☐	☐	________
Diarrhea	☐	☐	________
Blood noted in your bowel movement	☐	☐	________
Blood noted while wiping your rectum	☐	☐	________
Constipation	☐	☐	________
Do you require/need anything special to move your bowels, explain ________			
Change in bowel habit or function	☐	☐	________
Other ________			
GENITOURINARY ☐ **No concerns**			
Leakage of urine	☐	☐	________
Pain with urination	☐	☐	________
Getting up at night to urinate	☐	☐	________
If yes, number of times per night ________			
REPRODUCTIVE			
For Males			
Do you have erections adequate for intercourse	☐	☐	________
For Females			
Date of onset of your last period ________			
Is there a possibility that you might be pregnant	☐	☐	________
Number of pregnancies ________			
Number of live births ________			
Have you undergone menopause, what age	☐	☐	________
Approximate date of your last mammogram ________			
Approximate date of your last Pap smear ________			
INTEGUMENTARY ☐ **No concerns**			
Unexplained rash	☐	☐	________
Change in a mole	☐	☐	________
Abnormal nipple discharge	☐	☐	________
Breast lump	☐	☐	________
Other ________			
HEMATOLOGIC/LYMPHATIC ☐ **No concerns**			
Enlarged glands (lymph nodes)	☐	☐	________
Frequent or hard to control bleeding	☐	☐	________
Easy or excessive bleeding	☐	☐	________
Other ________			
ALLERGIES/IMMUNE			☐ See Allergy Record
Unexplained fever, within the past month	☐	☐	________
Night sweats requiring change of bedclothes	☐	☐	________
Other ________			
COPING/MENTAL HEALTH ☐ **No concerns**			
Problems falling asleep	☐	☐	________
Do you feel depressed most of the time	☐	☐	________
Thoughts of suicide	☐	☐	________
Commonly feel nervous, upset or anxious	☐	☐	________
Other ________			

TIME ________ **DATE** ________ Radiation Oncologist signature ________________

TIME ________ **DATE** ________ RN signature ________________
(when information was entered into Electronic Health Record)

Date ________ Signature of person completing the questionnaire ________________

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