LAKESHORE AREA
RADIATION ONCOLOGY
CENTER

Patient Name
DOB
MRN
Physician
FIN

Questionnaire
PATIENT SELF-REPORTED HEALTH INFORMATION - OUTPATIENT, LAROC

Name _____ Today's date _____

By what name should we call you? _____

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

What is the purpose for your appointment? _____

_____

MEDICATIONS

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

NAME OF MEDICINE	DOSE	AMOUNT EACH DAY	NAME OF MEDICINE	DOSE	AMOUNT EACH DAY

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 _____

_____

MEDICINE	DESCRIBE REACTION

PAST AND CURRENT MEDICAL CONDITIONS

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, and location of treating facility)

_____

OVER →

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

PAST AND CURRENT MEDICAL CONDITIONS *(CONTINUED)*

Have you ever had the following:

NO	YES		NO	YES	
☐	☐	Arthritis	☐	☐	Kidney stones
☐	☐	Asthma	☐	☐	Lupus
☐	☐	Autoimmune disorder	☐	☐	Obstructive sleep apnea (OSA)
☐	☐	Blood clots	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Previous cancers
		☐ Type I ☐ Type II	☐	☐	Rheumatic fever
☐	☐	Diverticulosis/Colitis	☐	☐	Scleroderma
☐	☐	Emphysema	☐	☐	Seizure
☐	☐	Gallstones	☐	☐	Stroke
☐	☐	Gastroesophageal reflux disease (GERD)	☐	☐	Thyroid problems
☐	☐	Heart attack/Heart disease	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis/Jaundice	☐	☐	Ulcers
☐	☐	High cholesterol	☐	☐	Venous access device
☐	☐	High blood pressure			☐ Power Port/CT scan compatible
☐	☐	Irregular heart rhythm			

Additional information _____

_____

List your previous surgeries: (type of surgery and body part)

Year Surgery and where

_____ _____

_____ _____

_____ _____

When you are filling out this form, is it September through April? ☐ No ☐ Yes

If yes, answer these two questions :

Have you had a flu shot? ☐ No ☐ Yes

Do you plan to get a flu shot this season? ☐ No ☐ Yes

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	CURRENT AGE	AGE AT TIME OF DEATH	DIAGNOSIS OF CANCER TYPE (IF ANY)	CAUSE OF DEATH IF NOT CANCER
Father				
Mother				

Do 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? _____

_____

_____

CONTINUE TO PAGE 3 ➔

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

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Number of children: _____
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 _____

OVER →

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	☐	☐	
Double vision	☐	☐	
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	☐	☐	
Fainting episodes	☐	☐	
Exercise intolerance	☐	☐	
Pain in calf(s) when walking	☐	☐	
Other _____			
RESPIRATORY ☐ **No concerns**			
Cough	☐	☐	
Difficulty breathing	☐	☐	
Shortness of breath	☐	☐	
Recent upper respiratory infection	☐	☐	
Other _____			
MUSCULOSKELETAL ☐ **No concerns**			
Any limitations in moving your joint or limb(s), describe _____	☐	☐	
Recent falls	☐	☐	
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 _____			

CONTINUE TO PAGE 5 ➔

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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
GASTROINTESTINAL ☐ **No concerns**			
Nausea	☐	☐	
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	☐	☐	
Urinating frequently	☐	☐	
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 _____			

OVER ➔

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
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 _____			

Date _____ Person Completing Form signature _____

If not patient, relationship to patient _____

OFFICE USE ONLY BELOW THE LINE

Blood pressure _____
Pulse _____
Respirations _____
Temperature _____
Height _____ (inches)
Weight _____ ☐ kg / ☐ lbs
Pulse oximetry _____ ☐ Room air ☐ Oxygen _____ liters/minute

TIME _____ **DATE** _____ Physician signature _____

WHEN INFORMATION WAS ENTERED INTO ELECTRONIC HEALTH RECORD:

TIME _____ **DATE** _____ RN signature _____