RADIATION ONCOLOGY
CLINICAL SUMMARY LIST and
MEDICAL HISTORY FORM
Page 1 of 4

Date __________________ Wt __________ Ht __________ BP ____________ T __________ P __________ R __________

Do you have an Advance Directive? (Durable Power of Attorney/Living Will) ☐ Yes ☐ No

If not, would you like information on Advance Health Care Directives: ☐ Yes ☐ No

What is your preferred language? ________________________________

Primary Care Physician: _______________________________________

Medical Oncologist: _________________________________________

Surgeon: _____________________________________________________

Other: _______________________________________________________

Past Medical History

Please list current and past medical problems that you have been treated for:

☐ Pacemaker/Defibrillator ☐ Alcoholism ☐ Diabetes ☐ HIV or AIDS ☐ Crohn’s Disease
☐ Cancer ☐ Asthma ☐ Glaucoma ☐ Ulcerative colitis ☐ Arthritis
☐ Prior Chemotherapy ☐ COPD ☐ Heart Trouble ☐ Kidney Stones ☐ Seizures
☐ Prior radiation ☐ Bleeding Disorder ☐ High Blood Pressure ☐ Lupus ☐ Stroke
☐ (To what body area) ____________________________ ☐ High Cholesterol ☐ Scleroderma ☐ Thyroid Disorders

☐ Fibromyalgia

Past Surgical History

Please list your previous surgeries, and the year that you had the surgery done in.

<table>
<thead>
<tr>
<th>Surgery (Any reaction to Anesthetic)</th>
<th>☐ No</th>
<th>☐ Yes</th>
<th>Hospital</th>
<th>Year</th>
</tr>
</thead>
</table>

Family History of Cancer

(Blood relatives: mother, father, children, grandparents, aunts or uncles, brothers and sisters)
### Allergies and Sensitivities

List any allergies to medications or foods that you may have and indicate how each affects you.

<table>
<thead>
<tr>
<th>Allergic To</th>
<th>Reaction</th>
<th>Allergic To</th>
<th>Reaction</th>
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Local Pharmacy: ___________________________ Phone: ___________________________

Location: ___________________________

### Current Medications

Please list all medications you are taking as of today, including those you buy without a doctor’s prescription (such as aspirin, cold tablets, nutritional supplements, and/or herbal medicines).

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Frequency</th>
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</table>

### Social History

Marital Status: □ Single □ Married □ Widowed □ Divorced Number of children: ____________

Occupation: ___________________________ Are you currently employed: □ Yes □ No

Any occupational hazards (like noise or chemical exposures)? □ Yes □ No

Describe: ____________________________

Emergency Contact/Relationship: ___________________________

Phone (Home) ___________________________ (Cell) ___________________________

Do you currently smoke? □ Yes □ No If so, how many packs per day ________ and for how many years? ________

If not, were you a former smoker? □ Yes □ No

Do you drink alcoholic beverages? □ Yes □ No Amount per week: ________

Have you ever used any recreational drugs (like marijuana, cocaine, heroin, intravenous drugs)? □ Yes □ No

Have you ever been emotionally, physically or sexually abused by your partner or someone important to you? □ Yes □ No

Have you ever been exploited physically or financially by someone important to you? □ Yes □ No
### Nutritional History

- Has there been any change in your appetite in the past 6 months?  
  - [ ] Yes  
  - [ ] No

- Have you gained or lost weight (more than 10 lbs) in 1 month without wanting to?  
  - [ ] Yes  
  - [ ] No

- If yes, how much gain or loss?  
  ________________________________________________

- Are you on a special diet?  
  - [ ] Yes  
  - [ ] No

### REVIEW OF SYSTEMS

Instructions: Check the box for each symptom that you have now or have had in the past three months. Fill in the blank spaces.

#### General:
- [ ] weakness  
- [ ] fatigue
- [ ] chills  
- [ ] night sweats
- [ ] change in sleeping habits

#### Eyes:
- [ ] glasses or contacts
- [ ] blank spots in your field of vision
- [ ] excessive tearing or discharge
- [ ] eye pain
- [ ] double vision
- [ ] last eye exam, date: ____________________________

#### Ears, Nose, Sinuses, Mouth and Throat:
- [ ] loss of trouble hearing  
- [ ] ringing
- [ ] post nasal drip  
- [ ] sore throat
- [ ] hoarseness
- [ ] bleeding gums  
- [ ] toothache
- [ ] last dental exam, date: ____________________________

#### Lungs:
- [ ] cough  
- [ ] wheezing
- [ ] shortness of breath  
- [ ] spitting up blood
- [ ] positive TB test
- [ ] last chest X-ray, date: ____________________________

#### Heart:
- [ ] chest pain
- [ ] palpitations (heart pounding)
- [ ] trouble breathing at night
- [ ] fatigue easily with exercise
- [ ] ankle swelling

#### Skin:
- [ ] itching
- [ ] rash
- [ ] change in color
- [ ] changes in warts, moles, or birthmarks

#### Breast:
- [ ] pain in breasts
- [ ] lumps in breast
- [ ] discharge from nipple
- [ ] last mammogram, date: ____________________________

#### Gastrointestinal:
- [ ] vomiting
- [ ] difficulty swallowing
- [ ] stomach or abdominal pain
- [ ] indigestion or heartburn
- [ ] ulcers
- [ ] changes in bowel habits
- [ ] blood in stools (or black stools)
- [ ] hemorrhoids
- [ ] sigmoid or colonoscopy, date: ____________________________

#### Musculoskeletal:
- [ ] pain
- [ ] weakness
- [ ] deformity
- [ ] joint swelling
- [ ] decreased range of motion

#### Vaginal and Urinary (female):
- [ ] vaginal itching or burning
- [ ] vaginal discharge
- [ ] sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- [ ] pain or frequent urination
- [ ] previous urinary infections
- [ ] trouble starting stream
- [ ] incontinence (leaking)

#### Gynecologic History:
- [ ] age of menarche: ____________________________
- [ ] last menstrual period, date: ____________________________
- [ ] problems with menstrual periods
- [ ] last pap smear, date: ____________________________
- [ ] method of contraception: ____________________________
- [ ] pregnancy, number (gravida): ____________________________
- [ ] births (para): ____________________________
- [ ] miscarriages or abortions, number: ____________________________
- [ ] prior birth control
- [ ] hormone replacement therapy

#### Genitals and Urinary (male):
- [ ] hernia
- [ ] discharge from penis
- [ ] pain or lump in testicles
- [ ] methods of contraception: ____________________________
- [ ] sexual difficulties
- [ ] sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- [ ] pain or frequent urination
- [ ] blood in urine
- [ ] trouble starting stream
- [ ] incontinence (leaking)

#### Hematologic and Lymphatic:
- [ ] easy bruising
- [ ] swollen lymph nodes

#### Endocrine:
- [ ] excessively hot
- [ ] always thirsty
- [ ] excessively cold
- [ ] always hungry

#### Nervous System:
- [ ] headaches
- [ ] numbness
- [ ] head injury
- [ ] seizures
- [ ] dizziness or passing out
- [ ] loss of coordination or balance

#### Psychological:
- [ ] nervousness or anxiety
- [ ] depression
- [ ] unable to to sleep
- [ ] nightmares
- [ ] memory loss
**Safety**

Have you fallen in the past six months?  □ Yes  □ No

Do you have problems with activities of daily living such as bathing, toileting or fixing meals?  □ Yes  □ No

If yes, explain: _____________________________________________________________

**PAIN SCREENING - TO BE COMPLETED BY THE CLINICAL STAFF / PATIENT**

1. Do you have pain now  □ No  □ Yes

2. Do you have any ongoing pain problems?  □ No  □ Yes  How long? __________

If patient answered yes to question 1 or 2 above, continue with questions 3-13.

**PAIN ASSESSMENT to be completed by Provider/Nurse/Patient**

3. Location: _____________________________________________________________

4. Intensity (0-10): Now ________ Usual

   On a 0-10 scale, what is your level of pain when it is at its best? __________________________

   On a 0-10 scale, what is your level of pain when it is at its worst? __________________________

   On a 0-10 scale, at what level of pain are you able to function as you want? __________________________

   Key to scale 0 - 10 (check one):

   □ 0  □ 1-2  □ 3-4  □ 5-6  □ 7-8  □ 9-10

5. Describe your pain (burning, aching, stabbing, dull, crushing):

6. What causes or increases your pain?

7. What symptoms are associated with your pain:

   □ Altered sleep  □ Nausea  □ Appetite

   □ Impaired concentration  □ Impaired mobility

   □ Depressed  □ Irritable  □ Other: __________________________

What do you do to relieve your pain?

What meds do you take for pain?

8. Are you satisfied with your pain control?  □ Yes  □ No

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**FOR PROVIDER USE ONLY**

**Education Needs Assessment**

Barriers to Learning:  □ None  □ Vision  □ Hearing  □ Cannot Read  □ Cannot Comprehend

   □ Language/needs interpreter  □ Other: __________________________

How does the patient best learn?  □ Pictures  □ Reading  □ Listening  □ Demonstration  □ Other __________________________

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Signature of Patient/Person Filling Out Form __________________________  Date __________________________

Provider Signature __________________________  Date __________________________