DT81311

UPSTATE
UNIVERSITY HOSPITAL

Department of Radiation Oncology
MEDICAL HISTORY FORM

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

RT#: _____

Marital Status: _____ Occupation: (former if retired) _____

Type of Industry: _____

Industry Street Address: _____

City: _____ State: _____ Zip Code: _____

MEDICAL HISTORY: Have you ever had or have any of the following?

	YES	NO		YES	NO	
1.	☐	☐	High Blood Pressure	☐	☐	14. Kidney/Urinary Tract Infection
2.	☐	☐	High Cholesterol	☐	☐	15. Menstrual Bleeding Irregularity/Infections
3.	☐	☐	Cataracts/Glaucoma/Tunnel Vision	☐	☐	16. Psychiatric Illness
4.	☐	☐	Irregular Heart Beat/Arrhythmia	☐	☐	17. Migraine/Frequent headaches
5.	☐	☐	Heart Disease (Heart Attack, Angina, etc.)	☐	☐	18. Seizures/Epilepsy
6.	☐	☐	Bronchitis	☐	☐	19. Swollen Glands/Lumps
7.	☐	☐	Asthma	☐	☐	20. Blood Clots in Legs
8.	☐	☐	Tuberculosis (TB)	☐	☐	21. Diabetes
9.	☐	☐	Emphysema	☐	☐	22. Thyroid Problems
10.	☐	☐	Stomach Ulcer/Duodenal Ulcer	☐	☐	23. Cancer (previous diagnosis or benign tumor)
11.	☐	☐	Hernia	☐	☐	24. Pneumonia
12.	☐	☐	Colitis	☐	☐	25. Hepatitis/Liver Trouble
13.	☐	☐	Arthritis	☐	☐	26. Other Medical Illnesses (Please List below)

If you have checked YES to any of the above please explain: _____

1. Please list any medications you are taking. Include vitamins, supplements and other medications you use occasionally. (Use additional sheet if necessary)

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

2. ☐Yes ☐No Do you have any allergies to medications? (**Describe any reactions**) _____

Patient's Name: _____ Account #: _____ MR#: _____ RT#: _____

YES NO Please answer each question.

3. ☐ ☐ Do you use alcohol? If yes, how often? _____

4. ☐ ☐ Do you use or have you ever used tobacco? If yes, how often? _____

5. ☐ ☐ Do you have visual, hearing, or other physical limitations? (Please explain)

6. ☐ ☐ Have you ever had surgery or been hospitalized? (Please explain)

7. ☐ ☐ Have you ever had previous radiation therapy and/or chemotherapy treatments? (Please explain)

8. ☐ ☐ Are you currently receiving chemotherapy or hormonal treatments? – Start Date? _____

9. ☐ ☐ Do you exercise? How often (daily, weekly, monthly)? _____

10. ☐ ☐ Do you need help with financial issues, such as health or disability insurances, income maintenance programs, paying for your prescriptions, home care and medical equipment, understanding short or long term care facilities, counseling for yourself or family members, or other social work services?

11. ☐ ☐ Are you interested in receiving information related to Spiritual Care Services available at University Hospital?

FAMILY STATE OF HEALTH HISTORY

Relationship	Age	State of Health (Good, Fair, Poor)	List any Diseases	If deceased, cause of death and age
Father				
Mother				
Siblings				
Children				

SYSTEMS REVIEW

Are you currently experiencing any of the following symptoms: (Please Check **YES** or **NO**)

YES NO

Constitutional Symptoms:
1. ☐ ☐ Recent Weight Change
2. ☐ ☐ Fevers or Chills
3. ☐ ☐ Decreased Energy

Eyes:
4. ☐ ☐ Visual Difficulty
5. ☐ ☐ Wear Glasses or Contact Lenses

Ears, Nose, Mouth, Throat:
6. ☐ ☐ Difficulty Swallowing
7. ☐ ☐ Chronic Sinus Problems
8. ☐ ☐ Nose Bleeds

Cardiovascular:
9. ☐ ☐ Chest Pain
10. ☐ ☐ Heart Palpitations

Respiratory:
11. ☐ ☐ Shortness of Breath
12. ☐ ☐ Coughing/Wheezing/Hoarseness
13. ☐ ☐ Spitting up Blood

Gastrointestinal:
14. ☐ ☐ Bowel Problems (Diarrhea, Constipation, etc.)
15. ☐ ☐ Rectal Bleeding
16. ☐ ☐ Abdominal Cramping

YES NO

Genitourinary:
17. ☐ ☐ Blood in Urine/Burning
18. ☐ ☐ Male - Testicle Pain
19. ☐ ☐ Female - Pain with or Irregular Periods

Integumentary:
20. ☐ ☐ Skin Problems (rashes, burning, bumps, color change)

Neurological:
21. ☐ ☐ Headaches
22. ☐ ☐ Fainting/Dizziness
23. ☐ ☐ Convulsions or Seizures

Hematologic/Lymphatic:
24. ☐ ☐ Easy Bruising or Bleeding
25. ☐ ☐ Past Transfusion

Psychiatric:
26. ☐ ☐ Anxiety/Depression
27. ☐ ☐ Memory Loss or Confusion

Endocrine:
28. ☐ ☐ Glandular or Hormone problem
29. ☐ ☐ Feel Hot or Cold

Musculoskeletal:
30. ☐ ☐ Unusual Aches or Pains (muscles or joints)
31. ☐ ☐ Weakness in Arms or Legs

If you checked "YES" to any of the above please explain or describe any other symptoms:

Does anyone in the family have a history of cancer or benign tumors? If yes, please explain.

I certify that the information completed on this form is true and complete to the best of my knowledge.

Signature of Patient or Guardian Date

TO BE COMPLETED BY ATTENDING PHYSICIAN ONLY

I, the undersigned, have reviewed all contents of this completed form and have discussed all positive pertinent data with the patient:

Attending Physician Signature: Printed Name/Title Date/Time: