BECAUSE OF YOU MOUNT CARMEL

MOUNT CARMEL RADIATION ONCOLOGY
NEW PATIENT SELF HISTORY/SELF ASSESSMENT FORM

Name: _____ Date _____
Reason for Consultation: _____
Physicians involved in your care: _____
Best Contact Phone #:_____

Can we leave a message: YES NO

Please check any ***current problems/symptoms***:

GENERAL /CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Hot flashes/night sweats
- ☐ Loss of appetite
- ☐ Sleep problems
- ☐ Weight loss
- ☐ Weight gain
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Difficulty walking
- ☐ Aids used for mobility:

  _____
- ☐ Bone Pain
- ☐ Jerking or twitching
- ☐ Joint pain/swelling
- ☐ Muscle weakness
- ☐ Other _____

INFECTIONS

- ☐ MRSA/VDRL/C-DIFF
- ☐ Risk of HIV exposure
- ☐ Other _____

CARDIO/PULMONARY

- ☐ Chest pain
- ☐ Cough
- ☐ Coughing blood
- ☐ Heart palpitations
- ☐ Shortness of breath
- ☐ Other _____

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Other _____

SKIN/INTEGUMENTARY

- ☐ Itching
- ☐ Rash
- ☐ Other _____

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GI/NUTRITIONAL

- ☐ Abdominal Pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Rectal pain/bleeding
- ☐ Special Diet
- ☐ Swallowing Problems
- ☐ Taste Changes
- ☐ Other _____

URINARY

- ☐ Blood in urine
- ☐ Difficulty with urinary control
- ☐ Painful urination
- ☐ Urgency
- ☐ Urinary Frequency
- ☐ Urinating at night
- ☐ Urinary tract infection
- ☐ Other _____

GYN/REPRODUCTION

- ☐ Changes in menstrual cycle
- ☐ Changes in sexual function
- ☐ Post- menopausal bleeding
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Other _____

EYES/EARS/NOSE/THROAT

- ☐ Earache/drainage
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Visual problems
- ☐ Other _____

HEMATOLOGICAL/LYMPHATIC

- ☐ Easy bruising/bleeding
- ☐ Enlarged lymph nodes
- ☐ Lymphedema
- ☐ Anemia
- ☐ Blood disorders
- ☐ Blood Transfusion
- ☐ Other _____

PSYCHOSOCIAL

- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Confusion
- ☐ Depression
- ☐ Panic attacks
- ☐ Other _____

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PAST MEDICAL HISTORY

CARDIO/NEUROLOGICAL

- ☐ CVA/Stroke
- ☐ Seizures
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Irregular heart rhythm
- ☐ Mitral valve prolapse
- ☐ Palpitation
- ☐ Varicose veins
- ☐ Vascular problems
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other _____

IMPLANTABLE DEVICES

- ☐ Defibrillator: Date inserted _____
- ☐ Pacemaker: Date inserted _____
- ☐ Port: Date inserted _____
- ☐ Other _____

URINARY

- ☐ Dialysis
- ☐ Enlarged Prostate
- ☐ Kidney Stones
- ☐ Prostate hormone treatment
- ☐ Other _____

ENDOCRINE/DIABETES

- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other endocrine disorders
- ☐ Other _____

PULMONARY

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Nebulizer
- ☐ Oxygen/CPAP/BiPap
- ☐ Pneumonia
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Other _____

GI/NUTRITIONAL

- ☐ Cirrhosis of the Liver
- ☐ Colitis
- ☐ Feeding Tube
- ☐ GERD/Heart Burn
- ☐ Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Ulcer
- ☐ Other _____

BECAUSE OF YOU
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NAME_____

DATE_____

PERSONAL HISTORY

- Married/Single/Widow/Divorced
- Currently Working YES NO
- Retired YES NO
- Adequate Transportation YES NO
- Living Will YES NO
- Durable Power of Healthcare Attorney YES NO
- Do you want information On Living Will or Durable Power of Healthcare Attorney? YES NO
- Where do you live?
  ☐ Home ☐ Nursing Facility ☐ Assisted Living
- How many people live in your home?_____

GYNECOLOGICAL HISTORY

- **Age of first period**_____
- **Age of first birth**_____
- **# of pregnancies**_____
- **# of live births**_____
- **Date of last menstrual period**_____
- **Date of last mammogram**_____
- **Date of last pap test**_____
- **Currently using birth control YES NO**
  Which type _____
- **Contraceptive hormone use YES NO**
  # of years _____
  Post menopause hormone use YES NO
  # of years _____

SOCIAL LIFESTYLE

☐ No tobacco use
☐ Active tobacco Use
# of years _____
Packs/day _____
☐ Occasional tobacco use
# of years _____
Packs/day _____
☐ Former tobacco use
Years quit _____
# of years _____
Packs/day _____

☐ No recreational drug use
☐ Recreational drug use
Type _____
# of years _____
☐ Former recreational drug use/type
_____
Years quit_____

☐ No alcohol use
☐ Active alcohol use
# of days/week_____
☐ Occasional alcohol use
#of drinks/year_____
☐ Former alcohol use
Years quit_____

Personal History of Cancer YES NO_____

Previous Chemotherapy/Radiation YES NO _____

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SURGERY HISTORY

Surgery	Date

FAMILY HISTORY

	LIVING	DECEASED	AGE	ILLNESSES
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Siblings/Other				

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MEDICATION LOG

Medication	Dose	Schedule (How Taken)	Doctor who prescribed

Allergies	Reaction

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