REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS: (continued)

Cardiovascular:
- Chest pain
- Palpmation (fast, irregular heart)
- Shortness of breath with exertion
- Swollen ankles

Respiratory:
- Chronic cough
- Chronic shortness of breath
- Chronic wheezing
- Coughing up blood
- Excessive phlegm

Gastrointestinal:
- Persistent nausea/vomiting
- Diarrhea
- Constipation
- Change in appearance of stool
- Chronic abdominal pain
- Bloody or very black stool
- Jaundice (yellow skin)

Genitourinary - Men Only:
- A discharge from your penis
- A lump or swelling of your testicle
- A decrease in your sex drive or potency more than you think is normal

Genitourinary - Woman Only:
- Unusual vaginal discharge
- Irregular vaginal bleeding
- Nipple discharge
- Lumps or soreness in the breast or nipple

Skin:
- Persistent skin rash
- Itching
- Chronic dry skin
- Moles or skin lumps that have changed in either size or color

Musculoskeletal:
- Back pain
- Joint pain
- Swelling in joints
- Muscle cramping
- Muscle weakness
- Muscle stiffness
- Arthritis

Neurologic:
- Headache
- Unable to move parts of your body at times
- Weakness
- Numbness, tingling sensations
- Seizures/convulsions
- Fainting spells
- Tremor/hands shaking
- Dizziness/vertigo

Psychological:
- Feeling depressed, sad
- Memory loss
- Difficulty concentrating

Endocrine:
- Cold or heat intolerance
- Excessive appetite
- Excessive thirst and urination
- Significant weight change

Allergic/Immunologic:
- Hives
- Hay fever
- Getting a lot of infections

PATIENT’S CONCERNS/NEEDS:

REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS: (continued)
SOCIAL HISTORY
Live with: □ Spouse □ Parents □ Relatives □ Friend □ Alone □ Other _____________

How many years of formal education have you completed?
1 □ No High School 2 □ Some High School 3 □ High School Diploma 4 □ Some College
5 □ College Degree 6 □ Graduate School 7 □ Special Education

Present employment status:
1 □ Working Part-Time 2 □ Working Full-Time 3 □ Unemployed 4 □ Retired 5 □ Disabled

What is your current occupation?
____________________________________________________________________
____________________________________________________________________

Previous occupation?
____________________________________________________________________
____________________________________________________________________

HEALTH HABITS:
1. Do you currently smoke cigarettes? □ Yes □ No
2. If you do not currently smoke cigarettes, have you ever smoked cigarettes? □ Yes □ No
3. If you currently smoke or have ever smoked:
   How many packs per day? _________ AND For how many years? _________

4. If you are an ex-smoker, how long ago did you stop smoking? ______________________________________

5. Do you drink alcohol? □ Yes □ No
6. On the average, how many drinks of alcohol and what type (beer, wine, whiskey) do you have per day? __________________________________________

Please answer the following:
1. Are you currently pregnant or any chance that you may be pregnant? □ Yes □ No
2. Are you a diabetic? □ Yes □ No
3. Do you have a Pacemaker? □ Yes □ No
4. Have you had any prior exposure to radiation? □ Yes □ No

If yes, please explain: ______________________________________________________

FAMILY HISTORY:
Has any BLOOD RELATIVE had any of the following? Please indicate by X’s which of the following health problems you, your parents, your grandparents, or your siblings have had (include blood relatives only).

<table>
<thead>
<tr>
<th>Self (1)</th>
<th>Parent (2)</th>
<th>Grand parent (3)</th>
<th>Brother/ sister (4)</th>
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<tr>
<td>Allergies</td>
<td>□ □ □ □</td>
<td>Tuberculosis □ □ □ □</td>
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<tr>
<td>Asthma</td>
<td>□ □ □ □</td>
<td>Kidney Disease □ □ □ □</td>
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<tr>
<td>Anemia</td>
<td>□ □ □ □</td>
<td>Ulcers □ □ □ □</td>
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<td>Diabetes</td>
<td>□ □ □ □</td>
<td>Hepatitis □ □ □ □</td>
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<tr>
<td>Alcoholism</td>
<td>□ □ □ □</td>
<td>Arthritis □ □ □ □</td>
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<tr>
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<td>□ □ □ □</td>
<td>High Cholesterol □ □ □ □</td>
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<td>Colon Polyp □ □ □ □</td>
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<td>Lung Cancer □ □ □ □</td>
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<td>Stroke</td>
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<td>Colon Cancer □ □ □ □</td>
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<td>Heart Disease</td>
<td>□ □ □ □</td>
<td>Breast Cancer □ □ □ □</td>
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<tr>
<td>High Blood Pressure</td>
<td>□ □ □ □</td>
<td>Prostate Cancer □ □ □ □</td>
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<td>Bronchitis</td>
<td>□ □ □ □</td>
<td>Skin Cancer □ □ □ □</td>
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<td>□ □ □ □</td>
<td>Leukemia □ □ □ □</td>
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<tr>
<td>Other Blood Disorder</td>
<td>□ □ □ □</td>
<td>Other Cancers (specify) □ □ □ □</td>
<td></td>
</tr>
</tbody>
</table>

REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS:
Please place a check mark beside any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don’t understand something place a question mark by it. Your doctor will discuss any positive responses with you.

General:
□ Fever, chills or sweat
□ Recent loss of appetite
□ Fatigue
□ Recent unexpected weight loss

Ears, Nose, Throat:
□ Earache
□ Ringing in ears
□ Decreased hearing
□ Difficulty swallowing
□ Frequent nose bleeds
□ Frequent sore throat
□ Prolonged hoarseness
□ Sinus trouble or congestion

Eyes:
□ Blurred or double vision
□ Eye pain or irritation
□ Eye discharge
□ Eye pain
□ Falling vision
□ Sensitivity to light
Advance Directive Done: Please bring a copy for your Medical Record
☐ Living Will  ☐ Medical Power of Attorney

SOCIAL HISTORY
Live with: ☐ Spouse  ☐ Parents  ☐ Relatives  ☐ Friend  ☐ Alone  ☐ Other _______________

How many years of formal education have you completed?
1 ☐ No High School  2 ☐ Some High School  3 ☐ High School Diploma  4 ☐ Some College
5 ☐ College Degree  6 ☐ Graduate School  7 ☐ Special Education

Present employment status:
1 ☐ Working Part-Time  2 ☐ Working Full-Time  3 ☐ Unemployed  4 ☐ Retired  5 ☐ Disabled

What is your current occupation? _____________________________________________________________

Previous occupation? ______________________________________________________________________

HEALTH HABITS:
1. Do you currently smoke cigarettes? ☐ Yes  ☐ No
2. If you do not currently smoke cigarettes, have you ever smoked cigarettes? ☐ Yes  ☐ No
3. If you currently smoke or have ever smoked:
   How many packs per day? _________ AND For how many years? _________
4. If you are an ex-smoker, how long ago did you stop smoking? ________________________________
5. Do you drink alcohol? ☐ Yes  ☐ No
6. On the average, how many drinks of alcohol and what type (beer, wine, whiskey) do you have per
day? ____________________________________________________________

Please answer the following:
1. Are you currently pregnant or any chance that you may be pregnant? ☐ Yes  ☐ No
2. Are you a diabetic? ☐ Yes  ☐ No
3. Do you have a Pacemaker? ☐ Yes  ☐ No
4. Have you had any prior exposure to radiation? ☐ Yes  ☐ No
   If yes, please explain: _________________________________________________________________

REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS:
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☐ Blurred or double vision  ☐ Sinus trouble or congestion
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Eyes:
☐ Eye pain or irritation  ☐ Eye discharge  ☐ Eye pain  ☐ Sinus trouble or congestion
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☐ Falling vision  ☐ Sensitivity to light
REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS: (continued)

Cardiovascular:
- Chest pain
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- Shortness of breath with exertion
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Respiratory:
- Chronic cough
- Chronic shortness of breath
- Wheezing
- Coughing up blood
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Gastrointestinal:
- Persistent nausea/vomiting
- Diarrhea
- Constipation
- Change in appearance of stool
- Chronic abdominal pain
- Bloody or very black stool
- Jaundice (yellow skin)

Genitourinary:
- Persistent trouble passing urine
- Blood in your urine
- Painful urination
- Increased frequency of urination

Genitourinary - Men Only:
- A discharge from your penis
- A lump or swelling of your testicle
- A lump or swelling more than you think is normal

Genitourinary - Woman Only:
- Unusual vaginal discharge
- Irregular vaginal bleeding
- Nipple discharge
- Lumps or soreness in the breast or nipple

Somatic:
- Headache
- Numbness, tingling sensations
- Seizures/convulsions
- Fainting spells
- Fatigue
- Dizziness/vertigo

Psychological:
- Feeling depressed, sad
- Memory loss
- Difficult concentrating

Endocrine:
- Cold or heat intolerance
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- Persistent skin rash
- Itching
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Musculoskeletal:
- Back pain
- Joint pain
- Swelling in joints
- Muscle cramping
- Muscle weakness
- Muscle stiffness
- Arthritis

Neurological:
- Hyperactivity, depression, anxiety
- Insomnia
- Numbness
- Pain

Other:
- Seizures/convulsions
- Excessive phlegm
- Chronic shortness of breath
- Chronic cough
- Swollen ankles
- Numbness, tingling sensations

Allergic/Immunologic:
- Hives
- Hay fever
- Getting a lot of infections
- Atopy (family history of allergies)

Medical or Surgical Oncologist: ___________________________________________________________________________

Name/Address/Phone of: ________________________________________________________________________________

WHO REFERRED YOU TO RADIATION ONCOLOGY? ________________________________________________________________________________

PATIENT’S CONCERNS/NEEDS:

COMMUNICATION LEARNING BARRIER: Yes No

PATIENT'S CONCERNS/NEEDS: What is the primary reason you have asked for a consultation at the Arizona Cancer Center:
- Evaluation and Treatment
- Treatment Recommendation
- Second opinion regarding previous treatment recommendations
- Other (please specify)

Would you like to talk to a social worker about any of the following:
- Living Situation
- Financial Situation
- Transportation
- Other

WHO REFERRED YOU TO RADIATION ONCOLOGY?
- Self
- Friend or Relative
- Other

- Another UMC Physician
- Other

- Name/Address/Phone of Medical or Surgical Oncologist

List all your medical illnesses and/or surgeries which are NOT related to cancer. Month/Year

1. __________________________________________________________________________________________
2. __________________________________________________________________________________________
3. __________________________________________________________________________________________
4. __________________________________________________________________________________________
5. __________________________________________________________________________________________
6. __________________________________________________________________________________________