UMC
UNIVERSITY MEDICAL CENTER
Tucson, Arizona

1 4 9 5

MEDICAL RECORD#

DOB

NAME

VISIT#

RADIATION ONCOLOGY
HEALTH HISTORY QUESTIONNAIRE

IDENTIFICATION DATA: Please fill in the following information. PLEASE PRINT.

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Date of birth_____ Home Phone ( )_____ Work Phone ( )_____

SEX:
1 ☐ Male
2 ☐ Female

CURRENT MARITAL STATUS:
1 ☐ Single
2 ☐ Married
3 ☐ Separated
4 ☐ Divorced
5 ☐ Widowed

ETHNIC ORIGIN:
1 ☐ Caucasian
2 ☐ African American
3 ☐ Hispanic
4 ☐ Asian
5 ☐ Native American
6 ☐ Other _____

COMMUNICATION LEARNING BARRIER: ☐ Yes ☐ No Interpreter_____

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 Physician Outside UMC

☐ 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_____ _____

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: _____

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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).

	Self (1)	Parent (2)	Grand parent (3)	Brother/ sister (4)		Self (1)	Parent (2)	Grand parent (3)	Brother/ sister (4)
Allergies	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	Ulcers	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	Colon Polyp	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	Lung Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Colon Cancer	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Breast Cancer	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Prostate Cancer	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	Leukemia	☐	☐	☐	☐
					Other Blood Disorder	☐	☐	☐	☐

Other Cancers (specify) _____

_____

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:
- ☐ Fevers, chills or sweat
- ☐ Recent loss of appetite
- ☐ Fatigue
- ☐ Recent unexpected weight loss

Eyes:
- ☐ Blurred or double vision
- ☐ Eye pain or irritation
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Failing vision
- ☐ Sensitivity to light

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

REVIEW OF SYMPTOMS AND PROBLEMS BY SYSTEMS: (continued)

Cardiovascular:
- ☐ Chest pain
- ☐ Fainting spells
- ☐ Palpitation (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:
- ☐ 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 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
- ☐ Join 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 SIGNATURE _____ DATE _____ TIME _____ ☐ AM ☐ PM

PHYSICIAN SIGNATURE _____ ID# _____ DATE _____ MILITARY TIME _____