RUSH UNIVERSITY MEDICAL CENTER

PATIENT INFORMATION FORM

Name: _____
Last *First* *Middle*

Address: _____
Street *City* *State* *Zip Code*

Social Security No.: _____ Date of Birth: _____ Age: _____

Why are you seeing the Radiation Oncologist today? _____

What problems (symptoms) are you having? _____

If you have had any of the following diagnostic procedures performed related to your present problem, please indicate when and where they were performed as accurately as you can recall.

TEST	WHERE PERFORMED	DATE
Biopsy		
Surgery		
X-rays		
Cat Scan		
MRI Scan		
Nuclear Medicine		

Have you had radiation therapy in the past? (Radiation or x-ray treatment for cancer) ( ) YES ( ) NO

If Yes, When? _____

Where? _____

Physician's Name: _____

Are you having, or have you had chemotherapy (drug treatment for cancer)? ( ) YES ( ) NO

If Yes, When? _____

Where? _____

Physician's Name: _____

Is future chemotherapy planned as part of your treatment? ( ) YES ( ) NO

Have you had any surgery in the past? ( ) YES ( ) NO

If Yes, complete the following:

TYPE OF SURGERY	WHERE (Hospital Name)	WHEN (Year)

Have you had any serious injuries? ( ) YES ( ) NO
If Yes, please describe: _____

_____

_____

_____

Tell us about your past medical illnesses, please check any you have had.

( ) Cancer of any type other than your present problem.
Please explain _____

( ) Heart attack, when? _____

( ) Stroke, when? _____

( ) Any other serious illness, describe: _____

( ) Rheumatic Fever
( ) Anemia
( ) Diabetes
( ) High Blood Pressure
( ) Kidney Disease
( ) Rheumatoid Arthritis

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING ON A REGULAR BASIS

DRUG NAME	DOSE SIZE	TIMES PER DAY	TAKEN SINCE WHEN
1.			
2.			
3.			

4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you allergic to **ANY** Drugs? ( ) YES ( ) NO

If Yes, please identify: _____

_____

_____

_____

FAMILY HISTORY: Please answer to the best of your recollection

RELATION	**GENERAL HEALTH**	**AGE**	**IF DECEASED - CAUSE**
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
CHILDREN NUMBER (_____)			

Have any other relatives had cancer, even skin cancer? ( ) YES ( ) NO

If yes, please list relationship and type of cancer: _____

_____

_____

_____

Are you presently employed outside your home? ( ) YES ( ) NO

What is your present occupation? _____

How many hours per week do you work outside the home? __ Hours

What has been your primary occupation(s) during your life?

1. _____

2. _____

3. _____

Have you ever worked with:

( ) Asbestos ( ) Radioactive Materials ( ) X-ray Machines

( ) Toxic Chemicals: _____

Tobacco History:

Do you now use or have you used in the past tobacco in any form? ( ) YES ( ) NO

- I have smoked for _____ years.
- I still smoke _____ packs/day.
- I quit smoking in _____ (what year).
- I have smoked as much as _____ packs/day.
- ( ) I have or ( ) do use snuff.
- ( ) I have or ( ) do use chewing tobacco.
- ( ) I have or ( ) do smoke a pipe.
- ( ) I have or ( ) do smoke cigars.

Alcohol History:

Do you drink or have you drank alcohol in the past? ( ) YES ( ) NO

- How much in a week? _____

Has your weight changed in the past: ( ) YES ( ) NO

( ) Three Months ( ) Gone up ____ pounds ( ) Gone down _____ pounds

( ) Six Months ( ) Gone up ____ pounds ( ) Gone down _____ pounds

( ) One Year ( ) Gone up ____ pounds ( ) Gone down _____ pounds

( ) My weight has changed because of _____.

Have you had night sweats? ( ) YES ( ) NO

Tell us about your eyes:

( ) I have had no problems with vision ( ) I wear glasses

( ) I wear contact lenses ( ) I have glaucoma

( ) I have cataracts ( ) I have a prosthetic eye (glass eye)
( ) right ( ) left

( ) I am blind ( ) in right eye – reason _____

( ) in left eye – reason _____

Tell us about your hearing:

( ) I can hear well for my age ( ) I wear a hearing aid(s)

( ) I have ringing or buzzing in my ears ( ) I have problems with dizziness

( ) I am deaf in ( ) right ear, ( ) left ear, ( ) both ears due to:

_____

Tell us about your teeth:

( ) My teeth are in good condition ( ) I wear dentures

( ) I have partial dentures ( ) My teeth need some work done

( ) My teeth are in poor condition

Have you had any of the following:

( ) Sore in my mouth ( ) Bleeding gums

( ) Frequent nose bleeds ( ) Persistent hoarseness

( ) Lump in my throat - Can you explain?

_____

Have you ever coughed up blood? ( ) NO

( ) YES, When? _____

How much? _____

What did your doctor do about it? _____

Have you had any problems with your heart? ( ) NO

( ) YES, What type of problem?

( ) Heart attack, when: _____

( ) Chest pain or pain in my arm ( ) Yes ( ) No

( ) Do you have shortness of breath?

( ) Yes - How often, and how severe? _____

( ) No

( ) Swelling of the feet or ankles ( ) Yes ( ) No

( ) Rapid heart beat or skipped beats ( ) Yes ( ) No

( ) Been told you have coronary artery disease

( ) Yes, explain: _____

( ) No

Have you had any problems with your lungs? ( ) NO

( ) YES, What type of problem?

( ) Emphysema

( ) Asthma

( ) Chronic cough

- Have you coughed up blood? ( ) Yes ( ) No

If you've had any of the above - tell us more about it: _____

_____

_____

Have you had any of the following problems? ( ) NO

( ) YES, please check any that apply to you and explain

( ) Regularly need and take antacids: _____

( ) Regularly need and take laxatives: _____

( ) Trouble swallowing: _____

( ) Nausea on a regular basis: _____

( ) Vomiting on a regular basis: _____

( ) Vomiting blood: _____

( ) Pain in abdomen (belly): _____

( ) Diarrhea on a regular basis: _____

( ) Constipation: _____

( ) Colitis: _____

( ) Diverticulitis: _____

( ) Rectal bleeding: _____

( ) Black tarry bowel movement: _____

( ) White bowel movements: _____

( ) Jaundice – When? _____

( ) Hepatitis – When? _____

( ) GI parasite infection – When / Explain: _____

_____

Do you have any of the following problems? ( ) NO

( ) YES, please check any that apply to you and explain

( ) Slow urinary stream: _____

( ) Difficulty in starting urinary stream: _____

( ) Urgency of urination (can't wait): _____

( ) Frequency of urination (go a lot): _____

( ) Get up at night more than one time - How many times? _____

( ) Incontinence (can't hold your urine): _____

( ) Burning with urination: _____

Has a PSA (Prostate Screening Blood Test) been done lately? ( ) NO

( ) YES, value: _____

Any of the following problems?

( ) Discharge from the penis ( ) Sore on the penis ( ) Lump in a testicle

( ) Had a testicle removed/explain: _____

( ) Had a testicle that never came down/explain: _____

When did you start your periods? Age: _____

Where/are your periods: ( ) Regular ( ) Irregular

Are you taking birth control pills? ( ) Yes ( ) No

Did you take birth control pills in the past? ( ) Yes, how long? _____ ( ) No

Are you taking hormones? ( ) Yes, how long? _____ ( ) No

what kind of hormones? _____

( ) Tablets ( ) Shots

Are you still having periods? ( ) Yes ( ) No

When was your last period? _____

Number of pregnancies: _____ Age at time of 1st child: _____

Age at menopause: _____

Do you have any of the following problems? ( ) NO

( ) YES, please check any that apply to you

( ) Vaginal discharge ( ) Spotting between periods

( ) Irregular periods ( ) Heavy periods

( ) Pain with periods

( ) When was you last pelvic exam?

Date: _____ Physician: _____

( ) Have you had a pap smear in the last year?

( ) Yes - Do you know the results? _____ ( ) NO

How is your sex life? (MALE OR FEMALE)

( ) Normal sexual relations ( ) Decrease in desire to have relations

( ) Decrease in ability to perform ( ) Can't perform sexual relations very well

( ) Cant' perform sexual relations at all anymore

Have you ever had any problems with your breasts? (MALE OR FEMALE) ( ) NO

( ) YES

( ) Swelling or enlargement of the breasts

( ) Lumps or masses in the breasts

( ) Other problems, please explain: _____

_____

Do you have any of the following?

( ) Nipple discharge: ( ) Right breast ( ) Left breast

( ) Bleeding from the breast: ( ) Right breast ( ) Left breast

( ) Mastitis (infection in the breast)

( ) Pain in the breasts

( ) Trouble nursing your children

( ) Have you ever had a mammogram? ( ) Yes, when was the last: _____ ( ) NO

Results: _____

Do you have any of the following? ( ) NO

( ) YES, please check any that apply to you and explain:

( ) Arthritis: _____

( ) Joint pain: _____

( ) Stiff joints: _____

( ) Muscle weakness: _____

( ) Swelling of feet, ankles, legs, or arms : _____

Do you have any skin problems? ( ) NO

( ) YES, please check any that apply to you:

( ) Sensitivity to sun exposure ( ) Itching

( ) Rash ( ) Dry skin

( ) Sunburn easily

Have you ever been diagnosed as having a skin cancer? ( ) NO

( ) YES

When and Where was this skin cancer located? _____

_____

Have you had any of the following problems in the past year? ( ) NO

( ) YES, please check any that apply to you:

( ) Loss of memory ( ) Frequent headaches

( ) Passing out ( ) Seizures

( ) Paralysis ( ) Tremors (shaking)

( ) Unsteady gait (problems walking), please explain: _____

Do you have any of the following problems? ( ) NO

( ) YES, please check any that apply to you:

( ) Intolerance to heat or cold ( ) Anemia (low red blood count)

( ) Bleeding tendency ( ) Easy to bruise

( ) Swelling of lymph glands, please explain: _____

_____

( ) Tendency to fall; when and where did you fall last? _____

_____

Who are resources for emotional/spiritual support? Check all that apply.

( ) Spouse ( ) Children ( ) Extended Family ( ) Other ( ) None

Do you have problems sleeping: ( ) NO

( ) YES, Are you taking sleeping pills? ( ) Yes ( ) No

How would you describe your energy level? Are you fatiqued/tired? _____

_____

How would you rank your overall quality of life on a scale of 0 to 100 with 100 being the best?
Mark (X) the square nearest to how you feel at this time.

0	10	20	30	40	50	60	70	80	90	100
POOR		FAIR		AVERAGE TO GOOD			VERY GOOD		EXCELLENT	

Explain if necessary : _____

_____

IF YOU WOULD LIKE TO MAKE ANY COMMENTS ABOUT YOUR CONDITION THAT YOU FEEL ARE IMPORTANT BUT WE HAVE NOT ASKED, PLEASE DO SO.

_____

_____

_____

_____

_____ _____

Patient or Guardian Signature Date

Thank you for filling out this questionnaire. You answers will help your doctor make the correct decisions for your best medical care.
Please return this form to the Front Desk. *Thank you!*