ADVANCED RADIATION CENTERS of NEW YORK
A DIVISION OF INTEGRATED MEDICAL PROFESSIONALS

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AdvancedRadiationCenters.com

The largest experience in Volumetric Arc Radiation Therapy (RapidArc) and Image Guidance Radiation Therapy (IGRT) in Metropolitan New York

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Where information is filled in, please confirm it is correct.

Last Name	First Name	MI	Date of Birth	Gender	Consultation Date
				M ❑ F ❑	

Address	City	State	Zip Code

Home Phone	Work Phone	Contact

Referral Information: *(please add all doctors that you would like us to be in contact with)*

Primary Care: _____ Other Doctors *(and specialty)*: _____

How did you decide to see us? *(check all)*:

❑ Referring Doctor ❑ Another Doctor: _____ ❑ Friend / Neighbor ❑ Radio Ad ❑ Web Search
❑ Print Ad *(where?)*: _____ Have you visited our website? ❑Y ❑N Site Comments: _____

Diagnosis or Reason for Today's Visit:

_____

_____

When Diagnosed, How Diagnosed, First Symptoms *(please describe)*:

_____

_____

_____

_____

_____

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Where information is filled in, please confirm it is correct.

What other medical problems do you have / have you had?

Problem	Yes/ No	Yes / No Doctor treated?	Details include approximate date of diagnosis, at least
AIDS / HIV positive	❑ Y ❑ N	❑ Y ❑ N	
Alzheimer's	❑ Y ❑ N	❑ Y ❑ N	
Arthritis	❑ Y ❑ N	❑ Y ❑ N	
Asthma	❑ Y ❑ N	❑ Y ❑ N	
Back Problems	❑ Y ❑ N	❑ Y ❑ N	
Blood Transfusions	❑ Y ❑ N	❑ Y ❑ N	
Bone Loss (Osteoporosis)	❑ Y ❑ N	❑ Y ❑ N	
Crohn's Disease or Ulcerative Colitis	❑ Y ❑ N	❑ Y ❑ N	
Cancer (other than the current one)	❑ Y ❑ N	❑ Y ❑ N	
Cardiac disease (or other heart)	❑ Y ❑ N	❑ Y ❑ N	
Diabetes	❑ Y ❑ N	❑ Y ❑ N	
Emphysema or Lung problems	❑ Y ❑ N	❑ Y ❑ N	
Lupus or Scleroderma (other than the current one)	❑ Y ❑ N	❑ Y ❑ N	
Gallstones	❑ Y ❑ N	❑ Y ❑ N	
GERD (reflux, heartburn)	❑ Y ❑ N	❑ Y ❑ N	
Hepatitis	❑ Y ❑ N	❑ Y ❑ N	
High Cholesterol	❑ Y ❑ N	❑ Y ❑ N	
High Blood Pressure	❑ Y ❑ N	❑ Y ❑ N	
Hypothyroid or Hyperthyroid	❑ Y ❑ N	❑ Y ❑ N	
Impotence or Infertility	❑ Y ❑ N	❑ Y ❑ N	
Kidney Disorders or Stones	❑ Y ❑ N	❑ Y ❑ N	

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Where information is filled in, please confirm it is correct.

What other medical problems do you have / have you had?

Problem	Yes/ No	Yes / No Doctor treated?	Details include approximate date of diagnosis, at least
History of mononucleosis	❑ Y ❑ N	❑ Y ❑ N	
Depression or mental illness	❑ Y ❑ N	❑ Y ❑ N	
Stroke or TIAs	❑ Y ❑ N	❑ Y ❑ N	

Prior Routine Tests

	Yes/ No	
Do you receive regular mammograms?	❑ Y ❑ N	Date of last mammogram:
Do you receive regular pap smears?	❑ Y ❑ N	Date of last pap smear:
Do you have regular PSA checks?	❑ Y ❑ N	Date of last PSA:
Do you have a pacemaker/defibrillator?	❑ Y ❑ N	Date of your last physical exam:

List all Major Surgeries *(provide details, including approximate dates)*:

Extended Hospitalizations *(stays in the hospital for more than 48 hours - provide details)*:

Have you ever had Radiation Therapy Treatment Before?

❑ Y ❑ N If YES, what part of your body and what dates:

Obstetric History *(females only)*:

Number of times pregnant: Number of children with which you've been pregnant:

Premature births: Abortions *(spontaneous or other)*: Living children:

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

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Medication History: *(list ALL medications you are now taking, including vitamins and over counter)*:

	Name of Drug	Strength	Taking for what problem
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Hormone Therapy:

Are you receiving hormone therapy? ❑ Y ❑ N Name of medication: _____

Date therapy started: _____

Chemotherapy History:

Have you received, or are you currently receiving chemotherapy treatments? ❑ Y ❑ N

	Chemotherapy name	# of cycles/cycle frequency	Date started	Date finished
1.				
2.				
3.				
4.				

Have you met with your chemotherapy doctor yet? ❑ Y ❑ N Name of doctor: _____

Has he / she scheduled you to start chemotherapy? ❑ Y ❑ N Date scheduled: _____

Allergies to Medications or other:

❑ I am NOT allergic to any medications.

❑ I am allergic to the following medications: *(List medications & reaction that you get, i.e. rash, fainting, etc.)*

1. _____

2. _____

3. _____

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Where information is filled in, please confirm it is correct.

Have you ever had anesthesia? ❑ Y ❑ N Explain:

Anyone in your family ever have anesthesia problems? ❑ Y ❑ N Explain:

Have you ever received intravenous contrast? ❑ Y ❑ N Explain:

If you received IV contrast, did you have any problems? ❑ Y ❑ N Explain:

Do you have any seafood allergies? ❑ Y ❑ N Explain:

Do you have any other allergies? ❑ Y ❑ N Explain:

Family History

Mother
❑ living ❑ deceased *(at age:_____ cause? _____)*
Mother's CANCER history or major medical problems:

Father
❑ living ❑ deceased *(at age:_____ cause? _____)*
Mother's CANCER history or major medical problems:

Other family members with history of cancer: *(list relationship and type of cancer)*

Smoking History

Do you currently smoke? ❑ Y ❑ N How many years? _____ How many packs / day? _____

Have you ever smoked? ❑ Y ❑ N When did you quit if you did smoke? _____ How many years? _____
How many packs / day? _____

Alcohol, Caffeine or Drug Use History

Do you currently drink alcoholic beverages? ❑ Y ❑ N
What kind, how often and how much?_____

Have your current habits of alcohol use changed? ❑ Y ❑ N If yes, explain: _____

Caffeine (coffee, soft drinks, etc) ❑ Y ❑ N how much?: _____

Other drug use, at present or in past? ❑ Y ❑ N Yes, Describe:_____

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

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Social History

Are you married? ❑ Y ❑ N if Yes, how long: _____

Do you have any children? ❑ Y ❑ N if Yes, list ages: _____

_____

Are you currently working? ❑ Y ❑ N

What is your occupation? *(or what was it before you retired, were disabled, etc.)?* _____

How long have you / did you work at your job(s)? _____ years.

Any chemical or other hazardous material exposure at work? ❑ Y ❑ N If yes, explain:_____

Are you currently on disability at your job? ❑ Y ❑ N

SYSTEM - SPECIFIC QUESTIONS *(check yes or no. if YES, please explain)*

GENERAL

Weight loss	❑ No	❑ Yes	_____
Weight gain	❑ No	❑ Yes	_____
Fever	❑ No	❑ Yes	_____
Chills	❑ No	❑ Yes	_____
Night Sweats	❑ No	❑ Yes	_____
Fatigue	❑ No	❑ Yes	_____

EYES

Use glasses or contacts	❑ No	❑ Yes	_____
Painful, itchy, or red eyes	❑ No	❑ Yes	_____
Blurry vision	❑ No	❑ Yes	_____
Double vision	❑ No	❑ Yes	_____
Spots, specks, flashing lights	❑ No	❑ Yes	_____
Excess tearing	❑ No	❑ Yes	_____
Very dry eyes	❑ No	❑ Yes	_____

EARS, NOSE, MOUTH, THROAT

Using hearing aids	❑ No	❑ Yes	_____
Changes in hearing	❑ No	❑ Yes	_____
Pain in ears	❑ No	❑ Yes	_____
Ringing in ears	❑ No	❑ Yes	_____
Discharge in ears	❑ No	❑ Yes	_____
Nasal bleeding / discharge	❑ No	❑ Yes	_____
Stuffy nose	❑ No	❑ Yes	_____
Changes in smell	❑ No	❑ Yes	_____
Changes is taste	❑ No	❑ Yes	_____
Use dentures?	❑ No	❑ Yes	_____
Hoarseness	❑ No	❑ Yes	_____
Spitting up blood	❑ No	❑ Yes	_____
Pain in mouth or throat	❑ No	❑ Yes	_____
Difficulty moving tongue	❑ No	❑ Yes	_____
Difficulty swallowing	❑ No	❑ Yes	_____

SKIN

Rashes	❑ No	❑ Yes	_____
Swelling	❑ No	❑ Yes	_____
Sores	❑ No	❑ Yes	_____
Itching	❑ No	❑ Yes	_____
Dryness	❑ No	❑ Yes	_____
Color Changes / Yellowing	❑ No	❑ Yes	_____
Changes in hair or nails	❑ No	❑ Yes	_____

FEMALES: BREAST

Lumps	❑ No	❑ Yes	_____
Soreness	❑ No	❑ Yes	_____
Clear nipple discharge	❑ No	❑ Yes	_____
Bloody nipple discharge	❑ No	❑ Yes	_____
Perform regular self-exams	❑ No	❑ Yes	_____

RESPIRATORY

Cough	❑ No	❑ Yes	_____
Excess sputum production	❑ No	❑ Yes	_____
Coughing up blood	❑ No	❑ Yes	_____
Shortness of breath	❑ No	❑ Yes	_____
History of pneumonia	❑ No	❑ Yes	_____
History of tuberculosis	❑ No	❑ Yes	_____

CARDIAC

Heart palpitations	❑ No	❑ Yes	_____
Heart murmurs	❑ No	❑ Yes	_____
Heart attacks	❑ No	❑ Yes	_____
Chest pain	❑ No	❑ Yes	_____
Pacemaker	❑ No	❑ Yes	_____

GASTROINTESTINAL

Heartburn	❑ No	❑ Yes	_____
Nausea	❑ No	❑ Yes	_____
Vomiting	❑ No	❑ Yes	_____
Indigestion	❑ No	❑ Yes	_____
Changes in stool color	❑ No	❑ Yes	_____
Changes in stool size	❑ No	❑ Yes	_____
Blood in stool	❑ No	❑ Yes	_____
Constipation	❑ No	❑ Yes	_____
Diverticulosis / Diverticulitis	❑ No	❑ Yes	_____
Diarrhea			

physician review _____

HEALTH HISTORY QUESTIONNAIRE (con't)

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SYSTEM - SPECIFIC QUESTIONS (con't) *(check yes or no. if YES, please explain)*

FEMALES: GENITAL

How old at first period? Age _____

Regular periods ❑ No ❑ Yes _____

Pain with intercourse ❑ No ❑ Yes _____

Very painful periods ❑ No ❑ Yes _____

Birth control pill use ❑ No ❑ Yes _____

How old at menopause? ❑ No ❑ Yes _____

Deceased libido ❑ No ❑ Yes _____

Vaginal discharge ❑ No ❑ Yes _____

Hormone replacement use ❑ No ❑ Yes _____

Complications w/pregnancies ❑ No ❑ Yes _____

MALES: GENITAL

Hernias ❑ No ❑ Yes _____

Discharge from penis ❑ No ❑ Yes _____

Testicular pains ❑ No ❑ Yes _____

Testicular masses ❑ No ❑ Yes _____

Decreased libido ❑ No ❑ Yes _____

ENDOCRINE

Thyroid dysfunction ❑ No ❑ Yes _____

Hot / Cold intolerance ❑ No ❑ Yes _____

Excessive sweating ❑ No ❑ Yes _____

Excessive thirst ❑ No ❑ Yes _____

Excessive hunger ❑ No ❑ Yes _____

PSYCHIATRIC

Nervousness ❑ No ❑ Yes _____

Depression ❑ No ❑ Yes _____

Mood swings ❑ No ❑ Yes _____

Feelings of hopelessness ❑ No ❑ Yes _____

VASCULAR

Poor circulation ❑ No ❑ Yes _____

Leg cramps ❑ No ❑ Yes _____

Varicose veins ❑ No ❑ Yes _____

Clots in veins ❑ No ❑ Yes _____

MUSCULOSKELETAL

Muscle or joint stifness ❑ No ❑ Yes _____

Stiffness ❑ No ❑ Yes _____

Arthritis ❑ No ❑ Yes _____

Gout ❑ No ❑ Yes _____

Backache ❑ No ❑ Yes _____

Swollen extremities ❑ No ❑ Yes _____

Decreased motion arms / legs ❑ No ❑ Yes _____

NEUROLOGIC

Fainting spells ❑ No ❑ Yes _____

Blackouts ❑ No ❑ Yes _____

Numbness ❑ No ❑ Yes _____

Weakness ❑ No ❑ Yes _____

Paralysis ❑ No ❑ Yes _____

Coordination problems ❑ No ❑ Yes _____

Migraines ❑ No ❑ Yes _____

Tremors ❑ No ❑ Yes _____

Involuntary movements ❑ No ❑ Yes _____

URINARY

Pain or burning w. urination ❑ No ❑ Yes _____

Blood in urine ❑ No ❑ Yes _____

Incontinence ❑ No ❑ Yes _____

Kidney Stones ❑ No ❑ Yes _____

Other: _____

CERTIFICATION

I attest that all of the information in this document is true and correct to the best of my knowledge and understand my physician will base his opinions and judgements on the same.

Patient Signature: _____ **Date** _____

physician review _____