CLEARWATER
Radiation Oncology

PATIENT HEALTH INFORMATION SHEET

NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____

ADDRESS:_____ **PHONE:**_____

INSURANCE:_____

PRIMARY CARE PHYSICIAN:_____

REFERRING PHYSICIAN:_____ **SURGEON (IF APPLICABLE):**_____

REASON FOR REFERRAL:_____

PAST & CURRENT MEDICAL PROBLEMS	ALL MEDICATIONS / VITAMINS (PRESCRIPTION & OVER THE COUNTER)
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

ALLERGIES:_____

HOSPITALIZATIONS & OPERATIONS (APPROXIMATE DATES AND LOCATION)

1._____

2._____

3._____

4._____

5._____

FAMILY HISTORY

FAMILY MEMBER	AGE	HEALTH PROBLEMS	IF DECEASED/AGE & CAUSE OF DEATH
MOTHER			
FATHER			
SISTERS			
BROTHERS			
CHILDREN			

ANY FAMILY MEMBER WITH CANCER?

RELATIONSHIP:_____ CANCER TYPE (IF KNOWN):_____

RELATIONSHIP:_____ CANCER TYPE (IF KNOWN):_____

ANY FAMILY MEMBER WITH BLOOD PROBLEM?

RELATIONSHIP:_____ BLOOD PROBLEM (IF KNOWN):_____

RELATIONSHIP:_____ BLOOD PROBLEM (IF KNOWN):_____

SOCIAL HISTORY

CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOWED

PLACE OF BIRTH:_____

PERMANENT RESIDENCE:_____

YOUR CURRENT OR PREVIOUS OCCUPATION:_____

SPOUSE'S AGE & CURRENT OR PREVIOUS OCCUPATION:_____

HOW MANY YEARS IN FLORIDA:_____

EVER SMOKE TOBACCO? YES NO

HOW MUCH?_____
HOW LONG?_____
WHEN QUIT?_____

EVER DRINK ALCOHOL? YES NO

HOW MUCH?_____
HOW OFTEN?_____

EVER EXPOSED TO RADIATION, TOXINS, CHEMICALS OR ASBESTOS? YES NO

WHEN & WHERE?_____

REVIEW OF SYSTEMS

PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

GENERAL:

HEALTH GOOD?	NO	YES
RECENT WEIGHT CHANGE	NO	YES
UNEXPLAINED FEVERS	NO	YES
NIGHT SWEATS	NO	YES

SKIN:

SKIN PROBLEMS	NO	YES
JAUNDICE	NO	YES
RASH	NO	YES
SKIN CANCERS	NO	YES

HEAD & NECK:

CATARACTS	NO	YES
GLAUCOMA	NO	YES
SINUS TROUBLES	NO	YES
HOARSENESS	NO	YES
HEADACHES	NO	YES
TROUBLE SWALLOWING	NO	YES

ENDOCRINE:

THYROID PROBLEMS	NO	YES
DIABETES	NO	YES
BIRTH CONTROL PILLS	NO	YES
ESTROGEN REPLACEMENT	NO	YES

RESPIRATORY:

PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES
COUGHING BLOOD	NO	YES
CHRONIC COUGH	NO	YES
ASTHMA	NO	YES
EMPHYSEMA	NO	YES
SHORTNESS OF BREATH	NO	YES

CARDIOVASCULAR:

HEART ATTACKS	NO	YES
CHEST PAIN/ANGINA	NO	YES
HIGH BLOOD PRESSURE	NO	YES
LEG SWELLING	NO	YES
NIGHT TIME SMOTHERING	NO	YES
RHEUMATIC FEVER	NO	YES
ABNORMAL RHYTHM	NO	YES
ABNORMAL CHOLESTEROL	NO	YES

GASTROINTESTINAL:

CONSTIPATION	NO	YES
DIARRHEA	NO	YES
VOMITING	NO	YES
VOMITING BLOOD	NO	YES
ULCER	NO	YES
RECTAL BLEEDING	NO	YES
GALLBLADDER TROUBLE	NO	YES
HEPATITIS	NO	YES
HEARTBURN	NO	YES
BLACK STOOLS	NO	YES
CHANGE IN BOWEL HABITS	NO	YES
PENCIL SHAPE STOOLS	NO	YES
CRAMPING	NO	YES
HEMORRHOIDS	NO	YES

GENITOURINARY:

LOSS OF URINE	NO	YES
FREQUENT URINATION	NO	YES
BURNING URINATION	NO	YES
PAINFUL URINATION	NO	YES
BLOOD IN URINE	NO	YES
KIDNEY TROUBLE	NO	YES
KIDNEY STONES	NO	YES
DIALYSIS	NO	YES

NEUROLOGICAL:

STROKE	NO	YES
SEIZURES	NO	YES
FAINTING SPELLS	NO	YES
PARALYSIS	NO	YES
DIZZINESS	NO	YES
MEMORY LOSS	NO	YES
CONFUSION	NO	YES

MUSCULOSKELETAL:

JOINT PAIN	NO	YES
BONE PAIN	NO	YES
ARTHRITIS	NO	YES
GOUT	NO	YES
OSTEOPOROSIS	NO	YES

REVIEW OF SYSTEMS

PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

HEMATOLOGIC:

BLOOD DISEASE	NO	YES
ANEMIA	NO	YES
DIFFICULTY HEALING	NO	YES
SWOLLEN LYMPH GLANDS	NO	YES
BLOOD CLOTS	NO	YES
PLATELET PROBLEMS	NO	YES
ABNORMAL BRUISING	NO	YES
ABNORMAL BLEEDING	NO	YES
HEAVY SURGICAL BLEEDING	NO	YES
HEAVY BLEEDING GUMS	NO	YES
HEAVY NASAL BLEEDING	NO	YES
BLOOD TRANSFUSIONS	NO	YES

HOW MANY?_____ WHEN?_____

IMMUNITY:

FREQUENT COLDS	NO	YES
ALLERGIES TO DUST/POLLEN	NO	YES
SERIOUS INFECTIONS	NO	YES

PSYCHIATRIC:

SEEN A PSYCHIATRIST	NO	YES
DEPRESSION	NO	YES
THOUGHTS OF SUICIDE	NO	YES
SLEEP TROUBLE	NO	YES
APPETITE CHANGE	NO	YES
ANXIETY ATTACKS	NO	YES

GYNECOLOGICAL:

HEAVY PERIODS NO YES

APPROX. AGE PERIOD STARTED:_____

APPROX. LAST PERIOD:_____

NUMBER OF PREGNANCIES:_____

MISCARRIAGES OR ABORTIONS:_____

DATE OF LAST MAMMOGRAM:_____

DATE OF LAST PAP SMEAR:_____

COMMENTS:_____