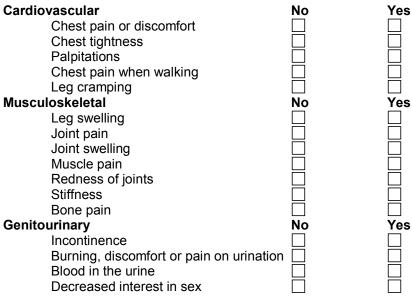
Office Use Only

GARNET HEALTH MEDICAL CENTER RADIATION ONCOLOGY DEPARTMENT PATIENT PROFILE

Name Date	
Name Date DOB Spouse's/Significant Other's Name	
PAST HISTORY:	
Have you ever had any of the following:	
No Yes No Yes Diabetes Mellitus	
If yes, please list:	
PAST SURGERIES (Indicate type of surgery and year): 1. 2. 3. 4. PAST INJURIES (indicate type of injury and year):	
PRIOR TREATMENT HISTORY: Have you ever had any of the following? Radiation Treatments No Yes If yes; where and when? Chemotherapy No Yes If yes; where, when, and what kind? How many treatments did you receive? When was your last treatment?	
Hormone Therapy	
If yes; where, when, and what kind?	
ARE YOU GOING TO RECEIVE CHEMOTHERAPY: No Yes Don't Know If yes; what drug/drugs and where?	
PRESENT MEDICATIONS (List medication name, dose, and how often taken): For Nurses' U 1. Height :	_
2. BP : 3. PR : 4. PR : 5. O2 Sat : Size :	- - -
ALLERGIES: Do you have any allergies to: Medications If yes; please specify:	

	Latex Allergy Food			No No	☐ Yes ☐ Yes	
	Seasonal/Env	blease specify: rironmental blease specify:		No	🗌 Yes	
FAMILY	HISTORY:					
Mother Father Siblings				e of Death	;	Age
Children						
		ncer in your f	amily?	No	🗌 Yes	
F 1 2		Type of			Aliv No No No No No	ve Yes Yes Yes Yes
Marital S	HISTORY/HAB tatus:] Single	BITS:	Uidowed	Divorce	ed 🗌	Separated
Occupat	ion:					
] Alcohol	College grac	ichool 🗌 Higl luate 🔲 Gra ou drink alcoho	duate School	(Masters/Doo	ctoral deg	
lt	yes (or quit); I					lay) 🗌 Heavy (3+/day)
	o you or did yo No	ou smoke or us	it, when?			
	ional Hazards	now much?	раскѕ ре	er day for	year	S.
· F	lave you ever l solvent	been exposed s, etc?	🗌 No	🗌 Yes		ad, asbestos, chemical
	nental Hazard	becify:				
F		been exposed secondhand sn		n, etc?		adon,
HOME/P	yes; please s ERSONAL ISS	SUES:			· · · · · · · · · · · · · · · · · · ·	
L	o you nave sp	ecial needs or No	Yes	n any or the fo	Showing:	
S F T C N	Child Care Spiritual Needs Fransportation Dressing yourse Making your me Anxieties or fea	erns	☐ If yes; ☐ If yes; ☐ If yes; ☐ If yes; ☐ If yes; ☐ If yes; ☐ If yes;	please specif please specif please specif please specif please specif	y: y: y: y: y:	
	Other needs		\square If yes;	please specif	y:	

WOMEN ONLY: (Men please proceed to Review of Systems)	
Name of Gynecologist: Date of last gynecologic exam/Pap smear:	
Date of last gynecologic examined sinear.	
Menstrual History: Age at onset: First day of your last period: Age at menopause:	
Do you or did you use birth control pills?	
Pregnancies: Number of pregnancies: Number of live births:	
Number of miscarriages: Number of abortions: Age at first live birth:	_
REVIEW OF SYSTEMS:	
Do you have any of the following:	
Constitutional/General	
🗌 Weight Loss 🗌 Weight Gain 🗌 Weight Stable	
If Gain or Loss; how much? pounds in (week/mo	nths/years)
No Yes	
Fatigue/Weakness	
Trouble sleeping	
Trouble maintaining sleep	
Night sweats	
Other (please specify):	
Eyes/Ears/Nose/Throat/Mouth No Yes	
Hearing problems	
Hearing loss	
Ĭf yes: □ Left □ Right □ Both	
Ringing in the ears	
Earache	
If yes: 🗌 Left 🔛 Right 🔛 Both	
Drainage from the ears	
Hoarseness of the voice	
Difficulty of swallowing	
Pain on swallowing	
Bleeding	
If yes; from where?:	
Sore throat	
Dry mouth	
Blindness	
Dental condition: Good Fair Require dental consultation	n
No Yes	'11
Dentures	
If yes: Upper Lower Both	
Respiratory/Pulmonary No Yes	
Cough	
Sputum 🗌 🗌	
Coughing up blood	
Shortness of breath	
Wheezing	
Painful breathing	
Trouble laying flat	
If yes: How many pillows do you sleep with:	
Use oxygen at home If yes; how ma	ny liters:
Other (please specify):	





(Check what best describe you)

In the past month:	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?						
2. Frequency How often have you had to urinate less than every two hours?						
3. Intermittency How often have you found you stopped and started again several times when you urinated?						
4. Urgency How often have you found it difficult to postpone urination?						
5. Weak Stream How often have you had a weak urinary stream?						
6. Straining How often have you had to strain while urinating?						
7. Nocturia	None	1 Time	2 Times	3 Times	4 Times	5 Times
How many times did you typically get up at night to urinate?						

Women Only:

Vaginal pain/discomfort Vaginal discharge Vaginal bleeding

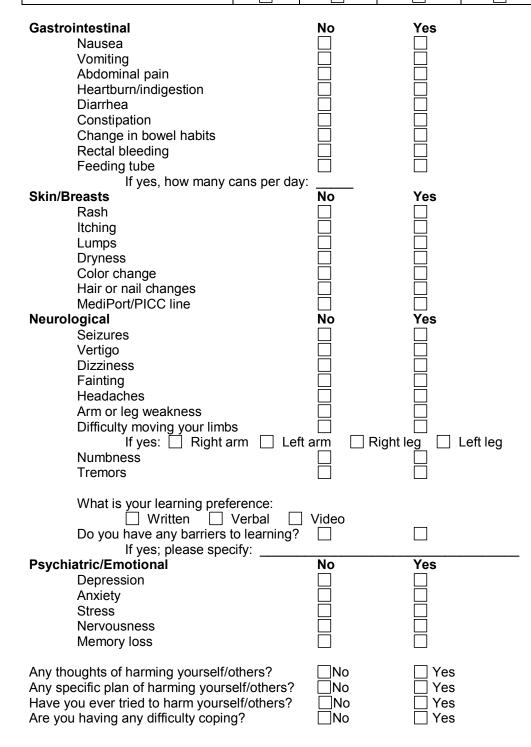
Yes

Men Only: (For those who may receive therapy to the Prostate or Pelvis, check what best describe you)

Over the past 6 months:					
1. How do you rate your confidence that you can get and keep an erection?	Very low	Low	Moderate	High	Very high
2. When you had erections with sexual stimulation how often were your erections hard enough for penetration?	Almost never/ never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always/ always

No

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never/ never	A few times (much less than half the	Sometimes (about half the time)	Most times (much more than half the	Almost always/ always
		time)		time)	
4. During sexual intercourse, how					
difficult was it to maintain your	Extremely	Very	Difficult	Slightly	Not
erection to completion of intercourse?	difficult	difficult		difficult	difficult
5. When you attempted sexual					
intercourse, how often was it	Almost	A few times	Sometimes	Most times	Almost
satisfactory for you?	never/	(much less	(about half the	(much more	always/
	never	than half the	time)	than half the	always
		time)	,	time)	-



Endocrine Heat or cold intolerance Increased perspiration Frequent urination Frequent thirst Hematologic/Lymphatic Ease of bruising Ease of bleeding Lumps in the neck/underarm/groin	No 	Yes
Activity/Performance Status Please check the description that best describe y Fully active, able to carry on all activities Restricted in physically strenuous activit Ambulatory and capable of self-care but Capable of limited self-care, confined to Completely disabled, cannot carry on an	without restrict y but ambulator unable to carry bed or chair mo	ions y and able to carry out light work out any work activities ore than 50% of waking hours
PAIN: Do you have any pain? If yes: Where is the pain? How long does the pain last? On a scale of 0 to 10, with 0 being no How much does it hurt right now? Best level Acceptable leve What makes the pain better? Does the pain prevent you from doing Are you taking any medication for the If yes; what? How effective is it in treating you ADVANCED DIRECTIVES: Please check all that apply: Living Will Do Not Resuscitate (DNR) Healthcare Proxy Name and phone number If any are checked, please bring a copy of PHARMACY Which Pharmacy do you use? Address: Telephone Number:	pain and 10 bei I Worst le normal activitie pain? No Ir pain? er of Healthcare with you to your	ng worst pain you can imagine; evel
Signature:		Date:
If not signed by the patient, please print full nam Name:		
Nursing Review by:		Date: