Jefferson™ Kimmel Cancer Center
NCI-designated

RADIATION ONCOLOGY: HEALTH ASSESSMENT FORM

Name:
Date of birth:
MRN:

Date of Visit: _____

Patient Email: _____

Race: (Please check one box)	**Sex:**	**Ethnicity: (Please check one box)**
☐ African American or Black	☐ Male	☐ Hispanic / Latino
☐ American Indian or Alaskan Native	☐ Female	☐ Non-Hispanic/Non-Latino
☐ Asian	☐ Transgender	☐ Unknown
☐ Caucasian or White		☐ Decline to answer
☐ Native Hawaiian or Other Pacific Islander		
☐ Unknown ☐ Decline to answer		

Reason for appointment: _____

Referring Physician: _____ **Specialty:** _____

Address: _____ **Phone#:**_____

Pharmacy: _____ **Phone#:**_____

Address: _____ **Fax#:**_____

Other Physician:	**Specialty:**	**Phone/Fax #:**

Medical History: Please list any past or current medical conditions below (i.e. heart burn, asthma, arthritis, etc…)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

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Name: _____DOB: _____MRN: _____

Do you have a pacemaker or defibrillator? Yes ☐ No ☐

If yes, what type? _____ *(Please provide a copy of your pacemaker or defibrillator card)*

Do you have an implanted device? (E.g. hip replacement) Yes ☐ No ☐

If yes, what type? _____

Do you have diabetes? Yes ☐ No ☐

Do you have high blood pressure? Yes ☐ No ☐

Do you have Lupus? Yes ☐ No ☐

Do you have thyroid disease? Yes ☐ No ☐

Do you have scleroderma? Yes ☐ No ☐

Do you have skin cancer? Yes ☐ No ☐

Have you ever had radiation therapy for any reason? Yes ☐ No ☐

Reason:	Date:	Location:
1.		
2.		
3.		

Have you been hospitalized in the past 6 months? Yes ☐ No ☐

If yes, reason for this hospitalization: _____

Have you had any previous operations? Yes ☐ No ☐

Date:	Surgery:	Hospital:
1.		
2.		
3.		
4.		

Medication(s) *include vitamins and herbal remedies

Name:	Dose:	Frequency:	Name:	Dose:	Frequency:
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

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Name: _____DOB: _____MRN: _____

Allergies (Medication or Food): ☐ Check here if no known allergies			
Allergy:	Reaction:	Allergy:	Reaction:
1.		3.	
2.		4.	

Social History:

Please indicate whether you are right or left handed: ☐ Right Handed ☐ Left Handed

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered

Do you live alone? Yes ☐ No ☐

Do you feel safe? Yes ☐ No ☐

Do you currently smoke? Yes ☐ No ☐

How much per day? _____ For how many years? _____

If "no", did you smoke regularly in the past? Yes ☐ No ☐

How much per day? _____ How long? _____ Date you quit: _____

Are you interested in information on smoking cessation? Yes ☐ No ☐

Do you or have you chewed tobacco? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐

How much per week? _____

Do you use illegal substances? Yes ☐ No ☐

If yes, please describe: _____

Have you fallen in the last 3 months? Yes ☐ No ☐

Are there any religious, ethnic, or cultural practices that need to be part of your care? Yes ☐ No ☐

If yes, please specify:

_____

Family History:

Have any of your family members been diagnosed with cancer? Yes ☐ No ☐

Type:	Relationship:	Age of diagnosis:

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Name: _____DOB: _____MRN: _____

Females Only:

Last Menstrual Period: _____ Age menstrual cycle began? _____

# of pregnancies: _____# of births: _____# of miscarriages: _____Age at first pregnancy:_____

Do you take estrogen now? Yes ☐ No ☐

Have you taken estrogen in the past? Yes ☐ No ☐

Do you use oral contraceptives: Now: _____ Past: _____ Bra size: _____ (breast cancer patients)

Males Only:

Do you get up at night to urinate? Yes ☐ No ☐

Do you have pain when you urinate? Yes ☐ No ☐

Any sexual issues (e.g. erectile dysfunction)? Yes ☐ No ☐

Date of last rectal exam: _____

Employment history / Insurance coverage:

Are you currently working? Yes ☐ No ☐

Current Occupation:
Past occupation(s):

Do you have insurance coverage for prescriptions? Yes ☐ No ☐

If "no", is paying for prescriptions a problem for you? Yes ☐ No ☐

Will you require transportation to and from your treatments? Yes ☐ No ☐

Do you have an advanced directive (living will)? Yes ☐ No ☐

Is there any additional information regarding your health care that you would like to share with us?

_____

_____

_____

_____

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MEDICAL HISTORY/SYSTEMS REVIEW: Check (Y)es or (N)o if you have experienced any of the items below within the past six (6) months.

General

Fever	Yes ☐ No ☐
Chills	Yes ☐ No ☐
Night sweats	Yes ☐ No ☐
Weight loss	_____#
Weight gain	_____#
Loss of appetite	Yes ☐ No ☐
Trouble sleeping	Yes ☐ No ☐

Eyes

Blurred / Double vision	Yes ☐ No ☐
Pain or redness	Yes ☐ No ☐
Glasses or contacts	Yes ☐ No ☐
Headache	Yes ☐ No ☐

Ears, Nose, Mouth, Throat

Ringing in ears	Yes ☐ No ☐
Decreased hearing	Yes ☐ No ☐
Earache	Yes ☐ No ☐
Nosebleed	
Dry mouth	Yes ☐ No ☐
Dentures	Yes ☐ No ☐
Sore throat/Hoarseness	Yes ☐ No ☐
Trouble swallowing	Yes ☐ No ☐
Neck Pain / Stiffness	Yes ☐ No ☐

Respiratory

Shortness of breath	Yes ☐ No ☐
Cough / wheezing	Yes ☐ No ☐
Coughing up blood	Yes ☐ No ☐

Cardiovascular

Chest pain / Discomfort	Yes ☐ No ☐
Abnormal heart rate	Yes ☐ No ☐
Irregular heartbeat	Yes ☐ No ☐
Leg swelling	Yes ☐ No ☐

Gastrointestinal

Nausea / vomiting	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐
Constipation	Yes ☐ No ☐
Vomiting blood	Yes ☐ No ☐
Blood in stool	Yes ☐ No ☐
Heartburn	Yes ☐ No ☐
Abdominal Pain / Discomfort	Yes ☐ No ☐

Heme/Lymph nodes

Ease of Bruising	Yes ☐ No ☐
Ease of Bleeding	Yes ☐ No ☐

Musculoskeletal

Muscle or joint pain	Yes ☐ No ☐
Stiffness	Yes ☐ No ☐
Back pain	Yes ☐ No ☐
Redness or swelling of joints	Yes ☐ No ☐

Skin/Breast

Rashes	Yes ☐ No ☐
Itching / Dryness	Yes ☐ No ☐
Breast lumps or masses	Yes ☐ No ☐
Nipple discharge or pain	Yes ☐ No ☐

Neurological

Dizziness	Yes ☐ No ☐
Fainting	Yes ☐ No ☐
Seizures	Yes ☐ No ☐
Weakness	Yes ☐ No ☐
Tingling	Yes ☐ No ☐
Numbness	Yes ☐ No ☐
Speech Problems	Yes ☐ No ☐

Psychiatric

Anxiety	Yes ☐ No ☐
Mood Changes	Yes ☐ No ☐
Memory loss	Yes ☐ No ☐
Thoughts of suicide	Yes ☐ No ☐

Bladder/Genitalia

Urinary frequency or urgency	Yes ☐ No ☐
Urinary burning or pain	Yes ☐ No ☐
Difficulty urinating	Yes ☐ No ☐
Blood in urine	Yes ☐ No ☐
Loss of bladder control	Yes ☐ No ☐
Change in urinary strength	Yes ☐ No ☐
Erectile dysfunction	Yes ☐ No ☐
Vaginal discharge / bleeding	Yes ☐ No ☐

Endocrine

Heat / Cold intolerance	Yes ☐ No ☐
Sweating	Yes ☐ No ☐
Frequent Urination	Yes ☐ No ☐
Thirst	Yes ☐ No ☐

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