Saint Mary's
A member of CHW

Radiation Oncology
645 N. Arlington Ave, Suite 120
Reno, Nevada 89503
(775) 770-7410

NEW PATIENT PAST MEDICAL HISTORY

Patient Name: ______________________________ Date: ____________________

CONSTITUTIONAL

Weight loss	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Sense of ill feeling	☐ Yes	☐ No
Fatigue / tired	☐ Yes	☐ No

EYES

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Changes in vision	☐ Yes	☐ No

EARS / NOSE / THROAT

Hearing loss	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Pain with swallowing	☐ Yes	☐ No

CARDIOVASCULAR

Chest pain	☐ Yes	☐ No
Chest tightness	☐ Yes	☐ No
Abnormal beats	☐ Yes	☐ No
Lightheadedness	☐ Yes	☐ No
Fluid retention	☐ Yes	☐ No

RESPIRATORY

Shortness of breath	☐ Yes	☐ No
Shortness of breath with exertion	☐ Yes	☐ No
Shortness of breath lying down	☐ Yes	☐ No
Shortness of breath at night	☐ Yes	☐ No

GASTROINTESTINAL

Abdominal pain	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Vomiting blood	☐ Yes	☐ No
Black / tarry stools	☐ Yes	☐ No
Bright red blood from rectum	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

ENDOCRINE

Heat or cold intolerance	☐ Yes	☐ No
Unexplained weight gain / loss	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No

MEDICATION ALLERGIES ☐ Yes ☐ No
(please list below and reaction):

____
____
____
____
____
____

GENITOURINARY

Urinary frequency	☐ Yes	☐ No
Burning with urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Leaking of urine	☐ Yes	☐ No
Urgency	☐ Yes	☐ No

MUSCULOSKELETAL

Joint pain	☐ Yes	☐ No
Muscle soreness	☐ Yes	☐ No
Swelling in arms / legs	☐ Yes	☐ No
Weakness	☐ Yes	☐ No

SKIN

Suspicious or changing moles	☐ Yes	☐ No
Dryness / itching	☐ Yes	☐ No

NEUROLOGIC

Headache	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Difficulty thinking	☐ Yes	☐ No
Difficulty with walking	☐ Yes	☐ No

PSYCHIATRIC

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

HEMATOLOGIC / LYMPHATIC

Lymphadenopathy	☐ Yes	☐ No
Excessive bruising / bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

ALLERGIC / IMMUNOLOGIC

Environmental allergies	☐ Yes	☐ No
Frequent infections	☐ Yes	☐ No

BREAST (if applicable)

Skin changes	☐ Yes	☐ No
Dimpling	☐ Yes	☐ No
Masses	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No

Last mammogram: ____________

CURRENT MEDICATIONS (dose, frequency):

____
____
____
____
____
____
____
____

TO BE COMPLETED BY MEDICAL STAFF

VITALS:

Wt: ____________________ Ht: ____________________

BP: ______ P: ______ R: ______ T: ______ OX: ______

KPS: ____

PAIN

Location: ____

Severity: ____________________________ (>4, notify MD)

Provoking factors: ___________________________________

Relieved by: ____

Onset: ____

Quality: ____

Pain goal: ____

CANCER HX

Diagnosis of cancer: _________________________________

Prior radiation / chemo: ______________________________

Date: ____

FAMILY CANCER HX

Mother: ____

Father: ____

Siblings: ____

Children: ____

Grandparents: ____

Aunts: ____

Uncles: ____

Cousins: ____

FEMALE

G: ______ P: ______ Ab: ______ Age 1st del: ______

Menarche: ____

Menopause: ____

ABUSE SCREENING

Malnutrition: ____

Not wanting to go home: ______________________________

Absence of reasonable explanation of injury:

____

Lack of eye contact: __________________________________

Poor hygiene: ____

Crying hopelessly: ____________________________________

Pt report any kind of assault: __________________________

____

PMHX

Diabetes: ____

Cardiac: ____

HTN: ____

Resp: ____

Neuro: ____

GI: ____

Bleeding prob: ____

Anemia: ____

Muscle pain / weakness: _______________________________

Nutritional assess: ____________________________________

OTHER MEDICAL:

____

____

____

____

SURGERIES:

____

____

____

____

____

____

Learning style: _______________________________________

Orientation: ____

Hearing: ____

Visual: ____

Support: ____

SMOKING HISTORY ☐ Yes ☐ No

Yrs smoked: ____________ Packs/day ____________

Quit: ____

ALCOHOL CONSUMPTION

☐Never ☐Rare ☐Seldom ☐Occasional ☐Everyday