FEMALE PATIENT QUESTIONNAIRE

NAME_______________ **DOB** _______ **AGE** ____ **DATE** _______________

REFERRING PHYSICIAN_______________ **REFERRAL DATE**__________ **PRIMARY PROVIDER**_______________

Current Cancer Type _______________

Previous Cancers? ☐ Y ☐ N Type_______________ Current status: ☐ Active ☐ Remission ☐ Cure ☐ Unknown

Recent immunizations: Circle all that apply Flu vaccine Shingles Pneumonia HPV H1N1 Date received_______________

PREVIOUS SURGERIES:

TYPE OF SURGERY	Approximate Date	TYPE OF SURGERY	Approximate Date

PRIOR HOSPITALIZATIONS/OTHER ILLNESSES/PAST INJURIES: (Describe) _______________

____

CHEMOTHERAPY? ☐ PRIOR ☐ CURRENT Where? _______________ Managing doctor? _______________

PREVIOUS RADIATION THERAPY? ☐ Y ☐ N Part of body? __________Dose ______ Dates/facility_______________

HORMONAL THERAPY? ☐ Y ☐ N Type_______________

MEDICAL HISTORY: Do you currently have or have history of (please check √)

☐ Lupus ☐ Mental Health Issues ☐ Scleroderma ☐ Collagen Vascular Disease ☐ High Blood Pressure ☐ Diabetes

HAVE YOU HAD ALLERGIES TO ANY OF THESE? ☐ Iodine ☐ IV dye ☐ Latex ☐ Adhesive

MEDICATION ALLERGIES / ADVERSE REACTION EXPERIENCED: ☐ None

Allergic to __________ Reaction __________ Allergic to __________ Reaction __________

Allergic to __________ Reaction __________ Allergic to __________ Reaction __________

Name and location of preferred pharmacy _______________

ANY PROBLEMS WITH PAIN ? ☐ Y ☐ N Where is your pain located?_______________ Rate of Pain 0-10 ______

Name and frequency of pain medications: _______________ Pain Control: ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY: Please list present health or cause of death, age, or age at death for family members:

	Living (Yes or No)	Age	Health now (or cause of death)	Any history of cancer?
Spouse:				
Father:				
Mother:				

Number of Biological Children: ________ Ages and Health:_______________

Brothers: Number Alive:________ Number Dead:________ Cause of death:_______________ History of cancer? __________

Sisters: Number Alive:________ Number Dead:________ Cause of death:_______________ History of cancer? __________

Other Family Members With Cancer: (relationship and type of cancer) _______________

SOCIAL HISTORY:

Past Education: ☐ H/S ☐ Voc Tech ☐ College # of years _____ ☐ Post-Grad Degree ☐ Current Student

Retired ☐ Y ☐ N **Military Service?** ☐ Y ☐ N # of years_____ **Primary Type of Work** (Current or previous):_______________

Current Work: ☐ FT ☐ PT ☐ On disability ☐ On medical leave ☐ Unemployed

Regular Exercise: ☐ None ☐ Limited ☐ Moderate ☐ Strenuous Hrs per week: ________

Hazardous exposure: ☐ None ☐ Asbestos ☐ Radioactive Materials ☐ Toxic Chemicals/Metals ☐ Textile Industry ☐ Rock Dust or Wood ☐ Commercial Insecticides ☐ Oil or Chemical Industry **Continued exposure**? ☐ Y ☐ N

Marital Status: ☐ Single ☐ Married ____# of yrs ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Live alone? ☐ Y ☐ N Who lives with you?_______________

Any history of substance use: ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Prescription Pain Meds

Have you ever smoked cigarettes? ☐ Y ☐ N Age started: ________ Avg. # packs per day: ________ If stopped, age: ________

2nd hand smoke exposure? ☐ Y ☐ N ☐ Current ☐ Past Where did exposure occur? ☐ Home ☐ Work ☐ Socially

List other tobacco products used_______________

Do you drink alcohol? ☐ Y ☐ N If yes, average # drinks/day:__________ Age started:________ If stopped, age:________

Do you have concerns about transportation for radiation treatments? ☐ Y ☐ N Who can drive you ?_______________

Do you have DNR (Do Not Resuscitate) or POLST (Physician Orders for Life Sustaining Treatment) orders in place? ☐ Y ☐ N **If yes, please bring a copy with you to your consultation.**

Did anyone recommend this facility to you (please check all that apply)? ☐ Physician ☐ Family ☐ Friend ☐ Other: __________ ☐ None

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REVIEW OF SYSTEMS: Place a ✓ by any of the following that you have/had a history of:

GENERAL

- ☐ Loss of weight (___lbs in last 3 months)
- ☐ Energy level ☐ Normal ☐ Less ☐ Better
- ☐ Fatigue ☐ None ☐ Mild ☐ Moderate ☐ Extreme
- ☐ Difficulty going asleep
- ☐ Difficulty staying asleep

EYES/EARS/NOSE/THROAT

- ☐ Glasses (Last exam __________)
- ☐ Glaucoma
- ☐ Cataracts ☐ Right ☐ Left
- ☐ Blindness ☐ Right ☐ Left
- ☐ Excess tearing/Double vision/Blurry vision
- ☐ Hearing problems (Describe): ________________________________
- ☐ Ringing in ears/Buzzing in ears
- ☐ Wearing hearing aids ☐ Rt ☐ Lt
- ☐ Dizziness
- ☐ Nasal problems
- ☐ Dental problems
- ☐ Dentures ☐ Partial ☐ Full
- ☐ Problems chewing or eating
- ☐ Problems swallowing
- ☐ Voice hoarseness/cause _____________

CARDIOVASCULAR

- ☐ Heart rate irregular/fast/racing/skip beats
- ☐ Heart problems/High blood pressure/CAD
- ☐ Prior heart attack/bypass surgery When? _____________
- ☐ Stroke
- ☐ Chest pain/Angina
- ☐ Pacemaker
- ☐ Feet/ankle swelling (unrelated to position)
- ☐ Cardiologist DR. ________________

RESPIRATORY

- ☐ Shortness of breath ☐ With walking ☐ With exertion ☐ Mild ☐ Moderate ☐ Severe
- ☐ Cough ☐ Chronic ☐ New onset
- Do you use cough medicine? ☐ Y ☐ N
- ☐ Coughed up blood in last 3 months
- ☐ Asthma/Emphysema/COPD
- ☐ Oxygen # liters __________
- ☐ Cigarette cough
- ☐ Chronic Bronchitis
- ☐ Sleep apnea

GASTROINTESTINAL

- ☐ Nausea/Vomiting/Vomiting Blood
- ☐ Loss of appetite
- ☐ Reflux Disease/Heartburn/GERD Meds _____________________
- ☐ Diarrhea Meds ________________
- ☐ Constipation Meds ______________
- ☐ Pain in abdomen
- ☐ Rectal pain
- ☐ Blood in stools or black stools
- ☐ Bowel incontinence
- ☐ Last colonoscopy __________ ☐ Results normal ☐ Results abnormal
- ☐ Liver disease/Hepatitis
- ☐ Diverticulitis
- ☐ Colon/intestinal polyps
- ☐ Inflammatory or irritable bowel disease
- ☐ GI tract bleeding
- ☐ Hemorrhoids
- ☐ Stomach ulcers
- ☐ Colostomy/ileostomy

GENITOURINARY

- ☐ Bladder empties fully
- ☐ Urinary frequency/urgency
- ☐ Burning on urination
- ☐ Nighttime urination (#_______)
- ☐ Incontinence (pads/day_________)
- ☐ Blood in urine

GYNECOLOGIC

- ☐ Age at first menses ________
- ☐ Regular Menses ☐ Irregular Menses
- ☐ Number of pregnancies ______
- ☐ Number of live births ______
- ☐ Age at first delivery
- ☐ Vaginal bleeding
- ☐ Hysterectomy for _________
- ☐ Ovaries removed ☐ Y ☐ N
- ☐ Hormone replacement ☐ Y ☐ N Type________________ # years_____
- ☐ Birth control ☐ Y ☐ N # years ______ Type ____________ When stopped ______

BREAST/SKIN

- ☐ Last mammogram ___________
- ☐ Nipple retraction/discharge
- ☐ Breast lump
- ☐ Skin dimpling
- ☐ Infection
- ☐ Prior biopsy _____________
- ☐ Sunburns easily
- ☐ Bad sunburns in past
- ☐ Tanning history (sun/booth)
- ☐ Bleeding/enlarging skin sores
- ☐ Moles changing color

MUSCULOSKELETAL

- ☐ Arthritis Where? ______________
- ☐ Joint pains Where? _____________
- ☐ Stiff joints Where? _____________
- ☐ Muscle weakness Where? ________
- ☐ Chronic back pain
- ☐ New skeletal pain Where? ___________________ Cause?___________________
- ☐ Fibromyalgia

MOBILITY

- ☐ Normal activity
- ☐ Balance problems
- ☐ Limited work
- ☐ Cannot work
- ☐ Limited self-care/ requires assistance
- ☐ Wheelchair bound/bedridden
- ☐ Use walker/cane/crutches
- ☐ Difficulty moving any extremity

NEUROLOGICAL

- ☐ ↑ Headache ☐ Recent ☐ Chronic
- ☐ Paralysis
- ☐ Tingling/numbness
- ☐ Seizures Frequency __________
- ☐ Dizziness/vertigo
- ☐ Passing out
- ☐ Memory Loss
- ☐ Difficulty walking
- ☐ Tremors
- ☐ Depression/Anxiety Treatment________________________
- ☐ Suicidal

ENDO/HEME/LYMPH

- ☐ Heat/cold intolerance
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Blood transfusion reaction
- ☐ Enlarged lymph nodes
- ☐ Soaking night sweats
- ☐ Fever (________ °F)
- ☐ Lymphedema
- ☐ History of diabetes
- ☐ History of thyroid problems

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IS THERE ANYTHING ELSE THAT YOU FEEL THAT WE NEED TO KNOW ABOUT YOU?

NURSE AND PHYSICIAN NOTES :

Height:__________ Weight:_________ BP:__________ Pulse:__________ Respirations:__________ Temperature:__________

Oxygen Saturation: _________ BMI: _____________

ARM/LEG MEASUREMENTS (circle dominant side) : RIGHT LEFT

	RIGHT	LEFT
10 / 15 cm Proximal	_______ cm	________ cm
10 / 15 cm Distal	_______ cm	________ cm
Wrist / Ankle	_______ cm	________ cm

COMMENTS:

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