GENERATIONS
Radiotherapy & Oncology PC

New Patient History
& Review of Systems

TODAY'S DATE

Welcome to Generations Radiotherapy & Oncology PC!

We're glad you've chosen to seek care here. Please provide answers to all of the following questions, as this will enable us to better care for you, offering you the safest, most efficient, and best experience possible.

NAME: YOUR AGE TODAY:

ADDRESS: DATE OF BIRTH:

CITY, STATE, ZIP:

HOME TELEPHONE:

MOBILE TELEPHONE:

E-MAIL ADDRESS:

ARE YOU COMFORTABLE WITH TEXT MESSAGING ON YOUR CELL PHONE? ☐ YES ☐ NO

Please note that by providing your e-mail address above, or indicating "yes" to the foregoing question, you consent to being contacted by either of these methods, recognizing that they may not meet HIPAA requirements for security.

WHAT DIAGNOSIS BRINGS YOU HERE TODAY?

WHICH OF YOUR DOCTORS IDENTIFIED THIS?

WHO IS YOUR PRIMARY CARE OR FAMILY PHYSICIAN?

IF YOU HAVE A SURGEON, PLEASE LIST THE NAME HERE.

LIST YOUR OTHER DOCTORS' NAMES HERE

LIST THE NAME OF YOUR PRIMARY HEALTH INSURANCE CARRIER HERE

DO YOU HAVE ANY ADVANCE DIRECTIVES? ☐ NO ☐ YES (PLEASE LIST)

IF YOU ARE OVER AGE 50, HAVE YOU HAD A COLONOSCOPY IN THE PAST 5 YEARS? ☐ NO ☐ YES ☐ N/A

THE FOLLOWING QUESTIONS APPLY TO WOMEN ONLY….

COULD YOU POSSIBLY BE PREGNANT? ☐ NO ☐ YES (IF YES, PLEASE ASK YOUR NURSE FOR A PREG. TEST)

ARE YOU UP-TO-DATE ON MAMMOGRAMS AND PAP SMEARS (BOTH SHOULD BE YEARLY)? ☐ NO ☐ YES

PAST MEDICAL HISTORY

Are you allergic to any of the following? If so, check the box and indicate specifically what you are allergic to, and what happens when you are exposed to that substance (e.g. you develop hives, or you become short of breath).

- ☐ Medications _____
- ☐ X-Ray Dye _____
- ☐ Other Medical Products _____
- ☐ Foods _____
- ☐ Other _____
- ☐ I have no known allergies.

Have you had any of the following? (Please check all that apply.)

☐ ANEMIA	☐ ASTHMA	☐ BLEEDING DISORDER	☐ BRONCHITIS
☐ COPD/EMPHYSEMA	☐ ANXIETY / DEPRESSION	☐ DIABETES	☐ FIBROMYALGIA
☐ HEART ATTACK	☐ CORONARY DISEASE	☐ HEPATITIS	☐ HIV OR AIDS
☐ HIGH BLOOD PRESSURE	☐ HIP/OTHER JOINT REPL.	☐ KIDNEY DISEASE	☐ LIVER DISEASE
☐ SARCOIDOSIS	☐ STROKE	☐ TUBERCULOSIS	☐ ULCERS
☐ AUTOIMMUNE DISEASE	☐ ENDOCRINE DISEASE	☐ OTHER DISEASE OR DISORDER NOT LISTED	

If you checked any of the boxes above, please provide details here:

_____

_____

_____

Women, how many times have you been pregnant? ____ ...any miscarraiges? ____ ...how many children now? ____

Men, are you currently sexually active? _____ Have you been treated for erectile dysfunction? _____

Are you currently on any medications? If so, please list them here:

MEDICATION	STRENGTH	FREQUENCY	PRESCRIBING DOCTOR

PAST MEDICAL HISTORY CONTINUED

Have you had any of the following immunizations? If so, please list the date of the most recent one.

☐ Pneumovax (the shot to prevent pneumonia) _____

☐ Influenza (the flu shot) _____

☐ Other Immunizations Within the Past 10 Years _____

Have you ever been hospitalized or had surgery for any reason, whether or not it relates to today's visit?

☐ YES ☐ NO If you answered yes, please provide details, including dates:

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you currently smoke or have you previously smoked?

☐ NO ☐ Yes, I currently smoke ___ pack(s) per day, and I've smoked for the past ___ years.

☐ Yes, I used to smoke ___ pack(s) per day. I smoked for ___ years, but I quit ___ years ago.

Do you currently or have you previously used smokeless tobacco?

☐ NO ☐ Yes, I currently use smokeless tobacco.

☐ Yes, I used to use smokeless tobacco, but I quit ___ years ago.

Do you currently or have you previously used any amount of alcohol?

☐ NO ☐ Yes, I currently consume an average of ___ drinks per _____ .

☐ Yes, I used to consume alcohol, but I quit ___ years ago.

Do you currently or have you previously used any street drugs or medication not prescribed for you?

☐ NO ☐ Yes, I currently use _____ .

☐ Yes, I used to use _____, but I quit ___ years ago.

☐ Check here if you have ever been treated for substance addiction (alcohol or drugs).

Have you been exposed to any known carcinogens (cancer-causing substances)?

☐ NO ☐ Yes (Please List) _____

Do you have a religious preference? If so, please list it here: _____

FAMILY HISTORY

Do any members of your immediate family (mother, father, brother, sister, or your children) have a history of cancer or tumors of any sort? If so, please check the appropriate box and indicate which cancer or tumor.

☐ Father _____
☐ Mother _____
☐ Brother(s) _____
☐ Sister(s) _____
☐ Son(s) _____
☐ Daughter(s)_____
☐ None of the Above

REVIEW OF SYSTEMS

The following is intended to jog your memory, in case we've missed anything. For each body system, please check the box if you have had any disorders or medical problems, other than those listed previously.

Constitutional or generalized body symptoms:

☐ FATIGUE ☐ WEIGHT LOSS ☐ FEVER ☐ NIGHT SWEATS ☐ CHILLS ☐ OTHER _____

Head, eyes, ears, nose, and throat :

☐ VISION CHANGE ☐ HEARING LOSS ☐ RINGING IN EARS ☐ NOSE BLEEDS ☐ HOARSENESS
☐ SWALLOWING TROUBLE OR PAIN ☐ EAR PAIN OR DRAINAGE ☐ OTHER _____

Lungs and respiratory system:

☐ SHORTNESS OF BREATH ☐ COUGH ☐ WHEEZING ☐ COUGHING-UP BLOOD ☐ OTHER _____

Heart and blood vessels:

☐ HEART PAIN (ANGINA) ☐ PALPITATIONS ☐ FAINTING ☐ LEG SWELLING ☐ OTHER _____

Digestive system:

☐ DIARRHEA ☐ CONSTIPATION ☐ IRRITABLE BOWEL SYNDROME ☐ OTHER _____

Urinary and reproductive system:

☐ INCONTINENCE ☐ PAIN WITH URINATION ☐ BLOOD IN URINE ☐ OTHER _____

Muscles and skeletal system:

☐ ARTHRITIS ☐ BONE PAIN ☐ MUSCLE PAIN ☐ OTHER _____

Brain and nervous system:

☐ HEADACHES ☐ NEUROPATHY ☐ SEIZURES ☐ OTHER _____

Psychiatric and emotional:

☐ DEPRESSION ☐ ANXIETY ☐ BIPOLAR DISORDER ☐ ADHD ☐ OTHER _____

Hormones and endocrine system:

☐ DIABETES ☐ HORMONAL IMBALANCE ☐ HEAT OR COLD INTOLERANCE ☐ OTHER _____

Skin disorders:

☐ PSORAISIS ☐ SCLERODERMA ☐ SKIN CANCER ☐ RASH ☐ DRYNESS ☐ OTHER _____