James Graham Brown Cancer Center
KentuckyOne Health

DEPT. OF RADIATION ONCOLOGY

PATIENT SELF HISTORY

If you need assistance in filling out this form, we will be happy to assist you.

Please bring this completed form to the clinic on the day of your appointment

This valuable information will assist us in preparing for your visit

DATE: _____

DEMOGRAPHICS

NAME: LAST _____ FIRST _____ MIDDLE _____

ADDRESS/CITY/STATE/ZIP:

BIRTHDATE: _____ AGE: _____ MARITAL STATUS: _____ RELIGION: _____

LANGUAGE SPOKEN: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT PERSON: _____ EMERGENCY CONTACT PHONE: _____

Would you like to receive communication regarding appointments via e-mail? Y ____ N ____

E-mail address: _____

We will provide your health information to all physicians listed below:

FAMILY OR INTERNAL MEDICINE _____

REFERRING **DOCTOR**: _____

OTHER DOCTORS INVOLVED IN YOUR CARE _____

YOUR UNDERSTANDING OF YOUR CURRENT PROBLEM: _____

NURSING:

Person with whom you wish to share medical information:

Name: _____ Relationship: _____ Phone #: _____

Advance Directive: Y ____ N ____ Copy Provided: ____ Y ____ N ____ Organ Donor: Y ____ N ____

PAST MEDICAL PROBLEMS: (check all that apply)

	YES	NO
High Blood Pressure	___	___
Diabetes	___	___
Heart Disease	___	___
Heart attack	___	___
Valve disease	___	___
Kidney Disease	___	___
Lung Disease	___	___
Emphysema	___	___
Asthma	___	___
Bronchitis	___	___
Ulcers	___	___
T.B.	___	___
Seizures	___	___
Stroke	___	___
Cancer	___	___
Emotional Disorders	___	___
Hepatitis	___	___
AIDS/HIV	___	___
Arthritis	___	___
Irritable Bowel	___	___
Skin Problems	___	___
Fibromyalgia	___	___
Reflux Disease	___	___
Migraines	___	___
Sexually Transmitted Disease	___	___

SOCIAL HISTORY (check all that apply)

	YES	NO	
Tobacco Use	___	___	
Cig packs per day	___	___	Yrs: _____
Smokeless Product	___	___	Yrs: _____
Quit?	___	___	Date: _____
Alcohol	___	___	
Amount	_____		
Illicit Drug Use	___	___	
Type	_____		

Highest School Grade Completed ___

High School Graduate ___ ___

College Graduate ___ ___

Employer or School _____

Children ___ ___

Number of children ___

Boys: ___

Girls: ___

Pregnancies: ___

PREVIOUS RADIATION TREATMENTS ___ FACILITY ___ YEAR ___

PREVIOUS SURGERIES/OPERATIONS

Surgery	Date
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____
4) _____	4) _____
5) _____	5) _____

DRUG ALLERGIES: _____

LATEX ALLERGY: YES ___ NO ___

OVER

MEDICATIONS: (list all medicines you take and the doses including vitamins, herbs, and over-the-counter)

FAMILY HISTORY: Please list all immediate family members with a history of cancer.
Include: Father, Mother, F Grandmother, F Grandfather, M Grandmother, M Grandfather, Brothers, Sisters, Sons, Daughters, Aunts, Uncles and 1st Cousins.

REVIEW OF SYSTEMS: (check all that apply)

GENERAL	YES	NO
Weakness	___	___
Weight Loss	___	___
Fever/chills	___	___
Night Sweats	___	___
EYES		
Blurred vision	___	___
Double vision	___	___
THROAT		
Difficulty swallowing	___	___
Change in voice	___	___
Change in taste	___	___
Pain	___	___
LUNG		
Shortness of Breath	___	___
Cough up Blood	___	___
Cough	___	___
Pain	___	___
Home O_2	___	___
MUSCULOSKELETAL		
Muscle aches	___	___
Bone pain	___	___
Joint pain	___	___
DIGESTIVE TRACT		
Decreased appetite	___	___
Nausea/Vomiting	___	___
Heartburn	___	___
Vomit blood	___	___
Dark stools/Light stools	___	___
Diarrhea	___	___
Constipation	___	___
Pain	___	___
REPRODUCTIVE		
Sexually active	___	___
Difficult erection	___	___
Loss of ejaculation	___	___
Penile discharge	___	___
Vaginal drainage	___	___
Vaginal bleeding	___	___
Painful intercourse	___	___
Last menstrual period	_____	
Age of Puberty	_____	
Age of Menopause	_____	

HEART	YES	NO
Chest Pain	___	___
Irregular heart beat	___	___
Palpitations	___	___
Swelling in ankles	___	___
Pacemaker	___	___
EARS		
Decreased hearing	___	___
Ringing in ear	___	___
Pain in ear	___	___
NECK		
Thyroid problems	___	___
Neck lump	___	___
Pain	___	___
BREAST		
Lump	___	___
Nipple discharge	___	___
Skin changes	___	___
Pain	___	___
SKIN		
Rash	___	___
Mole changes	___	___
Failure to heal	___	___
UROLOGICAL		
Frequent urination	___	___
Painful urination	___	___
Night Time urination	___	___
Blood in urine	___	___
Loss of control	___	___
Difficulty starting	___	___
NEUROLOGIC		
Headaches	___	___
Numbness	___	___
Tingling	___	___
Weakness	___	___
Seizures	___	___
Loss of consciousness	___	___

OVER