**SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** |  | | | | |  | |  | |  | |
|  | **Last First M.I.** | | | | |  | | **Today’s Date** | |  | |
|  | |  |  |  |  | |  | |  |  |  |
| **Referred By** | |  | **DOB** |  | **Marital Status** | |  | | **Height** |  | **Weight** |

**HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.**

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**PAST HISTORY: If you need additional space, it is provided on the last page.**

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| --- | --- | --- |
| **Surgeries (with dates)** |  | **Medical Conditions** |
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**Blood Transfusion History:**

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| --- | --- | --- |
| Yes No | If yes, when? |  |

**Reproductive History:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of pregnancies | |  | Number of children: |  | Age at first pregnancy: |  |
| Age at first period | |  | Age at last period: |  | Are you pregnant now | Y N |
| Hysterectomy: | Y N | | Ovaries removed | Y N |  | |
| Hormone use: | Y N | | Oral contraceptive use | Y N |  | |

**Preventive Health Maintenance: Please provide dates for each answer or write “none”**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Circle One: Male OR Female** | |  |  | |
| Last mammogram: |  |  | Last Prostate exam: |  |
| Last Pap smear: |  |  | Last PSA screening: |  |
| Last colonoscopy: |  |  | Last Flu vaccine: |  |
| Last bone density scan: |  |  |  |  |
| Last pneumonia vaccine: |  |  |  |  |

**SOCIAL HISTORY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance** | **Do you use?** | **What Type?** |  | **How Much?** |  | **How Often?** |  | **If quit, when?** |
| Alcohol: | Y N |  |  |  |  |  |  |  |
| Tobacco: | Y N |  |  |  |  |  |  |  |
| Caffeine: | Y N |  |  |  |  |  |  |  |
| Recreational Drugs: | Y N |  |  |  |  |  |  |  |

**FAMILY HISTORY: Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Relationship** | **Illness** |  | **Diagnosis Age** | **Deceased** | **Relationship:** | **Illness** |  | **Diagnosis Age** | **Deceased** |
| Mother: |  |  |  | Y N | Brothers: |  |  |  | Y N |
| Father: |  |  |  | Y N |  |  |  |  | Y N |
| Grandmother (P): |  |  |  | Y N |  |  |  |  | Y N |
| Grandfather (P): |  |  |  | Y N | Sisters: |  |  |  | Y N |
| Grandmother (M): |  |  |  | Y N |  |  |  |  | Y N |
| Grandfather (M): |  |  |  | Y N |  |  |  |  | Y N |
|  |  |  |  |  | Children: |  |  |  | Y N |
|  |  |  |  |  |  |  |  |  | Y N |
|  |  |  |  |  |  |  |  |  | Y N |

**REVIEW OF SYSTEMS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Constitutional** | |  | **Breast** | |  | **Skin** | |
| Weight Loss | Y N |  | Mass | Y N |  | Rash | Y N |
| Poor Energy Level | Y N |  | Pain | Y N |  | Nodules | Y N |
| Fever | Y N |  | Nipple Discharge | Y N |  | Itchiness | Y N |
| Chills | Y N |  | Change in Size | Y N |  | Lesions | Y N |
| Night Sweats | Y N |  | Change in Shape | Y N |  |  |  |
|  |  |  |  |  |  | **Neurological** | |
| **Eyes** | |  | **Gastrointestinal** | |  | Confusion | Y N |
| Double Vision | Y N |  | Nausea | Y N |  | Seizures | Y N |
| Vision Loss | Y N |  | Vomiting | Y N |  | Fainting Spells | Y N |
| Flashing Lights | Y N |  | Jaundice | Y N |  | Tremors | Y N |
|  |  |  | Abdominal Pain | Y N |  | Speech Change | Y N |
| **ENT/Mouth** | |  | Maroon/Black Stool | Y N |  | Headache | Y N |
| Ringing in Ears | Y N |  | Constipation | Y N |  | Abnormal Gait | Y N |
| Hearing Loss | Y N |  | Diarrhea | Y N |  | Weakness | Y N |
| Oral Ulcers | Y N |  | Vomiting Blood | Y N |  | Sensory Change | Y N |
| Mouth Pain | Y N |  | Difficulty Swallowing | Y N |  |  |  |
| Sore Throat | Y N |  |  |  |  | **Psychiatric** | |
| Difficulty Swallowing | Y N |  | **Urinary** | |  | Anxiety | Y N |
| Hoarseness | Y N |  | Painful Urination | Y N |  | Depression | Y N |
|  |  |  | Blood in Urine | Y N |  |  |  |
| **Cardiovascular** | |  | Increased Frequency | Y N |  | **Endocrine** | |
| Chest Pain | Y N |  | Loss of Control | Y N |  | Excessive Urine | Y N |
| Palpitations | Y N |  | Impotence | Y N |  | Excessive Thirst | Y N |
| Fainting Spells | Y N |  |  |  |  | Hot Flashes | Y N |
| Leg Swelling/Pain | Y N |  | **Gynecological** | |  | Heat/Cold Intolerance | Y N |
| Arm Swelling/Pain | Y N |  | Vaginal Discharge | Y N |  |  |  |
|  |  |  | Pelvic Pain | Y N |  | **Hematological** | |
| **Respiratory** | |  | Abnormal Bleeding | Y N |  | Nose Bleeds | Y N |
| Cough | Y N |  |  |  |  | Bleeding Gums | Y N |
| Wheezing | Y N |  | **Musculoskeletal** | |  | Easy Bruising | Y N |
| Shortness of Breath | Y N |  | Muscle Pain | Y N |  |  |  |
| Coughing Blood | Y N |  | Spine Tenderness | Y N |  | **Lymphatic** | |
| Pain with Breathing | Y N |  | Swollen Joints | Y N |  | Enlarged Lymph Nodes | Y N |
|  |  |  | Joint Redness | Y N |  | Swelling in Arms/Legs | Y N |
|  |  |  | Bone Pain | Y N |  |  |  |

**Radiation/Chemo History:**

Previous Radiation Therapy:  Yes No If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chemotherapy: Yes No If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Preferences:**

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? Yes No

Do you have a durable power of attorney or a living will? Yes No

Do you have a current Advanced Directive? Yes No

If Yes, please bring a copy in for our records.

If No, please let us know if you would like to make an appointment with a Nurse Practitioner

to complete your advance directives.

Are there any language barriers that the staff needs to be aware of? Yes No

Do you feel unsafe or threatened by anyone? Yes No

Do you have any thoughts of hurting yourself or anyone else? Yes No

**REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physician** |  | **Address** |  | **Phone Number** |
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**PHARMACY: Please list your pharmacy information.**

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| --- | --- | --- | --- | --- |
| **Pharmacy** |  | **Address** |  | **Phone Number** |
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**Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever accessed the VA for any services? Yes or No If so, what services did you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you eligible for Veteran’s Benefits due to a spouse’s military service? Yes or No**

**ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.**

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| **Patient Signature:** | |  | | | |
|  | | | |  | |
| **Patient Printed Name:** | | |  | | |
|  | | | |  | |
| **Date:** |  | | | |