

**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.

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

**Surgeries (with dates)**

**Medical Conditions**

**Blood Transfusion History:**

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.)

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Brothers:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Father:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Sisters:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Children:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

**REVIEW OF SYSTEMS**

Constitutional		Breast		Skin	
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Mass	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor Energy Level	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nodules	<input type="checkbox"/> Y <input type="checkbox"/> N
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Nipple Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Itchiness	<input type="checkbox"/> Y <input type="checkbox"/> N
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Size	<input type="checkbox"/> Y <input type="checkbox"/> N	Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Shape	<input type="checkbox"/> Y <input type="checkbox"/> N		
Eyes		Gastrointestinal		Neurological	
Double Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Confusion	<input type="checkbox"/> Y <input type="checkbox"/> N
Vision Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Flashing Lights	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N
		Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
		Maroon/Black Stool	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Change	<input type="checkbox"/> Y <input type="checkbox"/> N
		Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N	Headache	<input type="checkbox"/> Y <input type="checkbox"/> N
		Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Gait	<input type="checkbox"/> Y <input type="checkbox"/> N
		Vomiting Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
		Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensory Change	<input type="checkbox"/> Y <input type="checkbox"/> N
ENT/Mouth		Urinary		Psychiatric	
Ringing in Ears	<input type="checkbox"/> Y <input type="checkbox"/> N	Painful Urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in Urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Oral Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	Increased Frequency	<input type="checkbox"/> Y <input type="checkbox"/> N		
Mouth Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Control	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sore Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	Impotence	<input type="checkbox"/> Y <input type="checkbox"/> N		
Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N				
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N				
Cardiovascular		Gynecological		Endocrine	
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Urine	<input type="checkbox"/> Y <input type="checkbox"/> N
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Pelvic Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot Flashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Leg Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N			Heat/Cold Intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N
Arm Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N				
Respiratory		Musculoskeletal		Hematological	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscle Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nose Bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Spine Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Coughing Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Redness	<input type="checkbox"/> Y <input type="checkbox"/> N		
Pain with Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone Pain	<input type="checkbox"/> Y <input type="checkbox"/> N		
				Lymphatic	
				Enlarged Lymph Nodes	<input type="checkbox"/> Y <input type="checkbox"/> N
				Swelling in Arms/Legs	<input type="checkbox"/> Y <input type="checkbox"/> 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  
 No  
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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PHARMACY:** Please list your pharmacy information.

Pharmacy	Address	Phone Number
_____	_____	_____

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Current Medication Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

## Allergies & Adverse Reactions

Medication	Reaction

## Current Medications

Prescription, over-the-counter, and herbal remedies

Medication	Dose	Schedule

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_