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

Gender Identify (please check option below that applies):
☐ Male ☐ Female ☐ Female-to-Male ☐ Male-to-Female ☐ Genderqueer ☐ Choose not to disclose ☐ Other (please specify here) ________________________

Sexual orientation ☐ Lesbian ☐ Gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else

Sex assigned at birth__________________________ **Race**________________________

Ethnicity____________________________ **Disability Status**__________________________ **Preferred language**_______________________________

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.

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 pneumonia vaccine:	__________
Last Pap smear:	__________	Last Prostate exam:	__________
Last colonoscopy:	__________	Last PSA screening:	__________
Last bone density scan:	__________	Last Flu vaccine:	__________

Activity: walking, running, cycling, yoga, swimming, other: ______________________________

How often: daily, twice a week, three times a week, more: ______________________________

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:	____________	__________	☐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		
Weight Loss	☐Y	☐N
Poor Energy Level	☐Y	☐N
Fever	☐Y	☐N
Chills	☐Y	☐N
Night Sweats	☐Y	☐N

Eyes		
Double Vision	☐Y	☐N
Vision Loss	☐Y	☐N
Flashing Lights	☐Y	☐N

ENT/Mouth		
Ringing in Ears	☐Y	☐N
Hearing Loss	☐Y	☐N
Oral Ulcers	☐Y	☐N
Mouth Pain	☐Y	☐N
Sore Throat	☐Y	☐N
Difficulty Swallowing	☐Y	☐N
Hoarseness	☐Y	☐N

Cardiovascular		
Chest Pain	☐Y	☐N
Palpitations	☐Y	☐N
Fainting Spells	☐Y	☐N
Leg Swelling/Pain	☐Y	☐N
Arm Swelling/Pain	☐Y	☐N

Respiratory		
Cough	☐Y	☐N
Wheezing	☐Y	☐N
Shortness of Breath	☐Y	☐N
Coughing Blood	☐Y	☐N
Pain with Breathing	☐Y	☐N

Breast		
Mass	☐Y	☐N
Pain	☐Y	☐N
Nipple Discharge	☐Y	☐N
Change in Size	☐Y	☐N
Change in Shape	☐Y	☐N

Gastrointestinal		
Nausea	☐Y	☐N
Vomiting	☐Y	☐N
Jaundice	☐Y	☐N
Abdominal Pain	☐Y	☐N
Maroon/Black Stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Vomiting Blood	☐Y	☐N
Difficulty Swallowing	☐Y	☐N

Urinary		
Painful Urination	☐Y	☐N
Blood in Urine	☐Y	☐N
Increased Frequency	☐Y	☐N
Loss of Control	☐Y	☐N
Impotence	☐Y	☐N

Gynecological		
Vaginal Discharge	☐Y	☐N
Pelvic Pain	☐Y	☐N
Abnormal Bleeding	☐Y	☐N

Musculoskeletal		
Muscle Pain	☐Y	☐N
Spine Tenderness	☐Y	☐N
Swollen Joints	☐Y	☐N
Joint Redness	☐Y	☐N
Bone Pain	☐Y	☐N

Skin		
Rash	☐Y	☐N
Nodules	☐Y	☐N
Itchiness	☐Y	☐N
Lesions	☐Y	☐N

Neurological		
Confusion	☐Y	☐N
Seizures	☐Y	☐N
Fainting Spells	☐Y	☐N
Tremors	☐Y	☐N
Speech Change	☐Y	☐N
Headache	☐Y	☐N
Abnormal Gait	☐Y	☐N
Weakness	☐Y	☐N
Sensory Change	☐Y	☐N

Psychiatric		
Anxiety	☐Y	☐N
Depression	☐Y	☐N

Endocrine		
Excessive Urine	☐Y	☐N
Excessive Thirst	☐Y	☐N
Hot Flashes	☐Y	☐N
Heat/Cold Intolerance	☐Y	☐N

Hematological		
Nose Bleeds	☐Y	☐N
Bleeding Gums	☐Y	☐N
Easy Bruising	☐Y	☐N

Lymphatic		
Enlarged Lymph Nodes	☐Y	☐N
Swelling in Arms/Legs	☐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, would you like to make an appointment with a Nurse Practitioner to complete your advance directives. Yes 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

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.**

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Patient Signature: ________________

Patient Printed Name: ________________

Date: ________________