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:			☐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		Eyes		ENT/Mouth	
Weight Loss	☐Y ☐N	Double Vision	☐Y ☐N	Ringing in Ears	☐Y ☐N
Poor Energy Level	☐Y ☐N	Vision Loss	☐Y ☐N	Hearing Loss	☐Y ☐N
Fever	☐Y ☐N	Flashing Lights	☐Y ☐N	Oral Ulcers	☐Y ☐N
Chills	☐Y ☐N			Mouth Pain	☐Y ☐N
Night Sweats	☐Y ☐N			Sore Throat	☐Y ☐N
				Difficulty Swallowing	☐Y ☐N
				Hoarseness	☐Y ☐N

Cardiovascular		Respiratory	
Chest Pain	☐Y ☐N	Cough	☐Y ☐N
Palpitations	☐Y ☐N	Wheezing	☐Y ☐N
Fainting Spells	☐Y ☐N	Shortness of Breath	☐Y ☐N
Leg Swelling/Pain	☐Y ☐N	Coughing Blood	☐Y ☐N
Arm Swelling/Pain	☐Y ☐N	Pain with Breathing	☐Y ☐N

Breast		Gastrointestinal	
Mass	☐Y ☐N	Nausea	☐Y ☐N
Pain	☐Y ☐N	Vomiting	☐Y ☐N
Nipple Discharge	☐Y ☐N	Jaundice	☐Y ☐N
Change in Size	☐Y ☐N	Abdominal Pain	☐Y ☐N
Change in Shape	☐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, 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

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: _____

SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

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:** _____