Advanced Oncology Center, Inc.

2707 East Valley Blvd. Ste. 109
West Covina, CA 91709
Ph: (626) 956-8009
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Patient Health Questionnaire - Radiation Oncology

Patient Name: ________________________________ Date of Birth __________ Date: ________________

Reviewed on: (to be completed by staff)

History of allergy or other adverse reaction:

	YES	NO		YES	NO	If yes explain:
Antibiotics			Drug Allergy			
Morphine or narcotics			Known food allergy			
Aspirin or other pain meds			Environmental allergies			
Iodine/IV Contrast dye						

Medical History (please list past and current conditions)**:**

Medical Problems	Surgeries

Have you ever had:

	YES	NO		YES	NO
Lupus			Inflammatory Bowel Disease		
Scleroderma			Crohn's Disease		
Ulcerative Colitis			Previous Radiation Therapy		
Do you have a Pacemaker			Previous Chemotherapy		

Gynecological (female patients only):

		YES	NO
Date of first day of last period	**Is there a possibility you may be pregnant**		
Age periods first started	Have you ever taken hormone replacement medication?		
Number of pregnancies?	If yes, what type		
Number of children:	Date of last Mammogram:		
Number of miscarriages:	List any other tests:		
Age at first live birth?	Date of last Pap Smear?		

Breast History: Please check the correct answer

	YES	NO	RIGHT	LEFT	HOW LONG?
Do you have any lumps in your breasts?					
Do you have breast pain?					
Do you have nipple discharge?					

FAMILY HISTORY:

	If Living: Age	If Deceased: Age (at death)	Cause	Have any of your immediate relatives ever had cancer? If Yes, please list type of cancer?
Father				
Mother				
Siblings				

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Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow			
How often do you drink alcohol? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily			
	YES	NO	
Do you smoke tobacco?			If yes, how many years: ____________ and
Did you ever smoke tobacco?			On average, how many packs per day: ____________
Are you employed?			If yes, what is your occupation

SOCIAL HISTORY:

System Review: Please check "yes" or "no" box to indicate if you have any of the following symptoms

	YES	NO		YES	NO
General			**Musculoskeletal**		
Fevers			Joint Pain		
Night Sweats			Joint Swelling		
Chills			Injuries or Joint Fractures		
Recent Weight change			Back Pain		
If yes, _________lbs			**Skin**		
Eyes			Hives		
Eye Disease or injury			Eczema		
Do you wear glasses			Rash		
Change in vision			Abnormal pigmentation		
Ears, Nose & Throat			**Neurological**		
Change in hearing			Fainting spells		
Voice change			Convulsions		
Sore throat			Paralysis		
Respiratory			Headaches		
Shortness of breath			**Psychiatric**		
Cough			Depression		
Wheezing			Anxiety		
Cardiovascular			Memory Loss or Confusion		
Chest Pain			Insomnia		
Shortness of breath while walking or lying down			**Endocrine**		
Difficulty walking two blocks			Excessive thirst		
Swelling of hands, feet or ankles			Intolerance to heat/cold		
Heart Murmur			**Hematologic**		
Irregular heart beat			Anemia		
Gastrointestinal			Have you had abnormal bruising or bleeding		
Bleeding with bowel movements			Swollen glands		
Black stool			**Immunology/Allergy**		
Recent change in bowel habits			Allergies to animals or plants		
Frequent diarrhea			Runny Nose		
Heartburn or indigestion			Itchy Eyes		
Constipation					
Genitourinary					
Frequent urination					
Night time urination					
Burning or painful urination					
Blood in urine					
Sexual Difficulty					
Incontinence					

The Past Medical History, Family History, Social History, and Review of Symptoms were reviewed with the patient by the physician(s) noted below:

____

Physician Signature Date