

Inova Fairfax Hospital
Department of Radiation Oncology

Patient Information

Patient Name _____ Visit Date _____

Phone (home) _____ (work) _____ (cell) _____

E-mail address: _____

Please **circle** the number or email above if we can leave personal/private messages for you there.

Marital Status: _____ With whom do you live? _____

Age _____ DOB ____/____/____ Are you currently employed: No Yes Retired

Current or former occupation: _____

Referring physician: _____

Primary Care Physician: _____

Other physicians you would like us to keep informed: _____

Current medical problem or reason for visit:

Major Medical Problems (diabetes, heart, lung, blood pressure, etc): _____

Prior Surgeries & Dates: _____

Hospitalizations & Dates: _____

Previous radiation treatment? No Yes When/Where? _____

Previous or current chemotherapy? No Yes When/Where? _____

History of cancer in the family _____

Current Medications:	For Treatment of:	Dose:	How Often?

Drug Allergies? No Yes Please list: _____

Height: _____ Weight: _____ Recent weight loss? _____ pounds _____ months

Do you smoke now? No Yes Did you smoke in the past? No Yes

When did you stop? _____ How many packs per day? _____ How many years? _____

About how much alcohol do you drink?

None Occasionally 1-2 drinks/day 2-3 drinks/day More than 3 drinks

Have you ever been treated for drug/alcohol addiction? No Yes

We do not release information about you without your consent. If you wish to give us permission to speak freely with certain relatives or friends, please list their names and relationship to you.

Emergency Contact(s):

Name _____ Relation _____ Phone _____

Do you have pain? _____

Do you have transportation to come for treatments? _____

Insurance company? _____

Usual Pharmacy? _____ phone _____

Inova Fairfax Hospital
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Review of Systems

Place patient label here

Are you currently experiencing any of the following?

	Y	N						
Constitutional			Genitourinary			Swollen lymph nodes		
Fatigue			Excessive dribbling			Night sweats		
Weight Loss			Burning upon urination			Frequent infections		
Eyes			Reproductive – Male			Immunology		
Contacts/glasses			Frequent urination at night			Rheumatoid arthritis		
Glaucoma			Blood in urine			Lupus		
Cataracts			Kidney stones			Scleroderma		
Eye pain			Reproductive-Female			Psychiatric		
Ears/Nose/Throat/Mouth			Discharge/sore penis			Depression		
Hearing loss			Hernias			Anxiety		
Ringings in ears			Testicular pain or lumps					
Pain in ears			HIV/AIDS					
Chronic nose obstruction			Sexually active					
Repeated nosebleeds			Reproductive-Female					
Persistent sore gums			Breast lumps					
Dentures			Nipple discharge					
Prolonged hoarseness			Hormone therapy					
Dry mouth			Last menstrual period / /					
Respiratory			Sexually active					
Chronic cough			HIV/AIDS					
Difficulty breathing			Number of pregnancies:					
Asthma			Number of live births:					
Emphysema			Skin					
Bronchitis			Lumps or bumps					
Sit up to breathe easier?			Color change in moles					
Tuberculosis			Hives or rashes					
Pneumonia			Prior skin cancer					
Coughing up blood			Shingles					
Cardiovascular			Musculoskeletal					
High blood pressure			Numbness in arms or legs					
Heart disease			Tingling in arms or legs					
Pacemaker			Problems walking					
Chest pain			Paralysis					
Gastrointestinal			Shaking/tremors					
Chronic abdominal pain			Joint pain/arthritis					
Persistent nausea/vomiting			Neurologic					
Heartburn			Headaches					
Appetite loss			Dizziness/fainting					
Vomiting blood			Memory loss					
Diarrhea			Seizures					
Blood/clay covered stools			Speech changes					
Hemorrhoids			Numbness					
Constipation			Weakness in arms or legs					
Hepatitis			Endocrine					
Gall bladder disease			Thyroid trouble					
Difficulty swallowing liquids			Diabetes					
Difficulty swallowing solids			If yes, do you take insulin?					
			Hemo/lymphatic					
			Anemia					
			Bruising/bleeding					