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CENTRAL KANSAS CANCER CENTER
RADIATION ONCOLOCY

Martin J. Bell, M.D. **Brenda Avery, P.A.-C .**

Medical History

NAME: _____ **DATE:_____**

1. Please list any medications that you are allergic to:
   _____ _____
   _____ _____

2. Do you have any known allergy to IV contrast or iodine: Yes_____ No_____
3. Have you had previous exposure to radiation for treatment of cancer or other illness? Yes_____ No_____

If yes, please explain: _____

4. Have you ever had any of the following:

____Heart Disease ____Infectious Disease (HIV, AIDS, Hepatitis, etc.)
____Arthritis ____High Blood Pressure
____Blood Transfusions ____Stomach Problems/Ulcers
____Diabetes ____Kidney
____Pacemaker
____Cancer or Tumor Type: _____
____Other Problems Type: _____

5. Has a family member ever had a diagnosis of cancer: Yes_____ No_____

If yes, please list relationship and type of cancer and age:
_____

Smoking History: Yes_____ No_____ Cigarettes_____ Cigar_____ Pipe_____ Chewing Tobacco_____
If yes, please limit amount used per day _____
If yes, please list number of years used_____
If you do not smoke of or use tobacco products now, have you previously? Yes_____ No_____
If yes, please list number of years you previously smoked or used tobacco products:_____
Alcohol History: None_____ Daily_____ Occasionally/Socially_____ History of alcoholism_____
Recreational Drug Use: Yes_____ No_____

ADDITIONAL INFORMATION:
Last Colonoscopy: _____ Where: _____
Approximate Date of last Blood Work: _____ Where:_____
Flu Vaccine: Yes_____ No___ Date:_____ Pneumonia Vaccine: Yes____ No____ Date:_____

General:

- ☐ Fevers, chills, or night sweats
- ☐ Recent loss of appetite
- ☐ Fatigue
- ☐ Recent unexplained weight loss

Eyes:

- ☐ Blurred or double vision
- ☐ Eye pain or irritation
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Failing vision
- ☐ Sensitivity to light

Ear, Nose, Throat:

- ☐ Earache
- ☐ Ringing in ears
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Frequent nosebleeds
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Sinus trouble or congestion

Cardiovascular:

- ☐ Chest pain
- ☐ Fainting spells
- ☐ Palpitation (fast, irregular heartbeat)
- ☐ Shortness of breath with exertion
- ☐ Swollen ankles

Respiratory:

- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing
- ☐ Coughing up blood
- ☐ Excessive phlegm

Gastrointestinal:

- ☐ Persistent nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in appearance of stool
- ☐ Chronic abdominal pain
- ☐ Bloody or very black stool
- ☐ Jaundice (yellow skin)
- ☐ Heartburn
- ☐ Diagnosis of Crohn's Disease
- ☐ Diagnosis of Irritable Bowel Syndrome
- ☐ Hemorrhoids

Endocrine:

- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst and urination
- ☐ Significant weight change

Allergic/Immunologic:

- ☐ Hives
- ☐ Hay fever
- ☐ Other allergies:

_____

- ☐ Getting lots of infection

Musculoskeletal:

- ☐ Back pain
- ☐ Joint pain
- ☐ Swelling in joints
- ☐ Muscle cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Arthritis

Skin:

- ☐ Skin rashes
- ☐ Itching
- ☐ Chronic dry skin
- ☐ Suspicious moles or other skin abnormalities you are concerned about

Hematologic/Lymphatic:

- ☐ Excessive bruising or bleeding
- ☐ Swollen gland in neck, armpits, or groin

Neurologic:

- ☐ Headache
- ☐ Unable to move parts of your body at times
- ☐ Weakness
- ☐ Numbness/tingling sensations
- ☐ Seizures/Convulsion
- ☐ Fainting spells
- ☐ Tremor/hands shaking
- ☐ Dizziness/vertigo

Psychological:

- ☐ Feeling depressed or sad
- ☐ Memory loss
- ☐ Difficulty concentrating
- ☐ Phobias/unexplained fears
- ☐ No pleasure in life anymore

IF YOU ARE A MAN:

- ☐ Painful urination
- ☐ Blood in Urine
- ☐ Increased frequency of urination
- ☐ Loss of control of your urine
- ☐ Difficulty starting urine flow
- ☐ Urinating more than twice a night
- ☐ Constant feeling that you need to urinate
- ☐ Weak and/or slow urine stream
- ☐ Burning or discharge from penis
- ☐ Swelling or lumps on testicles
- ☐ Painful testicles
- ☐ Difficulty getting or maintaining erection

IF YOU ARE A WOMAN:

- ☐ Unusual vaginal discharge
- ☐ Loss of control of your urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Genital sores
- ☐ Nipple discharge
- ☐ Breast mass or tenderness
  - Age of first menstrual period _____
  - Date of last menstrual period _____
  - Have you had a hysterectomy? ___
  - Number of pregnancies ____
  - Number of children born alive ____
  - Number of premature births ____
  - Number of miscarriages ____
  - Number of stillbirths ____
  - Have you ever had an abortion ___
  - Do you perform self-breast exams once a month? ____
  - Date of last mammogram _____
  - Have you used hormone pills, shots, or creams _____

7. Please list any other concerns that you want the doctor to be aware of: _____

_____

_____

Please mark an 'X' where your current pain is located on the diagram below and rate pain level on a scale of 0-10.