CKCC
CENTRAL KANSAS CANCER CENTER
RADIATION ONCOLOGY
Martin J. Bell, M.D. • Brenda Avery, P.A.-C.
1133 College Ave.
Bldg. E, Suite 140
Manhattan, KS 66502
Office: (785) 539–2500
Toll Free: (877) 509–2500
Fax: (785) 539–2225

Medical History

NAME:_____ DATE:_____

Have you ever had any of the following:

___ Asthma

___Arthritis

___Anemia/Blood Disorder

___Blood Transfusions

___Diabetes

___Cancer or Tumor

Type: _____

___Heart Disease

___Infectious Disease (HIV, AIDS, Hepatitis, etc.)

___High Blood Pressure

___Stomach Problems/Ulcers

___Kidney or Bladder Trouble

___Other Problems

Type:_____

Has a family member ever had a diagnosis of cancer: ___Yes ___No
If yes, please list relationship and type of cancer:

_____

_____

Please list any medications that you are sensitive or allergic to:

_____ _____

_____ _____

Do you have any known allergy to IV contrast or iodine: ___Yes ___No

Smoking History: ___Cigarettes ___Cigar ___Pipe ___Chewing Tobacco
If yes, please list amount used per day _____
If yes, please list number of years used _____
If you do not smoke 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:_____

Date of most recent flu vaccine: _____ Pneumonia vaccine: _____

MEDICAL REVIEW OF SYMPTOMS:
Please mark any symptoms that you have had or are currently having.

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

Ears, 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
□ Palpitations (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

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, creams? ____

Endocrine:
□ Cold or heat intolerance
□ Excessive appetite
□ Excessive thirst and urination
□ Significant weight change

Allergic/Immunologic:
□Hives
□ Hay fever
□ Other allergies

_____
□ Getting lots of infections

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 glands in neck, armpits, or groin

Psychological:
□ Feeling depressed or sad
□ Memory loss
□ Difficulty concentrating
□ Phobias/unexplained fears
□ No pleasure in life anymore

Neurologic:
□ Headache
□ Unable to move parts of your body at times
□ Weakness
□ Numbness/tingling sensations
□ Seizures/convulsions
□ Fainting spells
□ Tremor/hands shaking
□ Dizziness/vertigo

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 an erection

Have you ever had previous exposure to radiation other than CT scans and/or x-rays? ___Yes ___No

If yes, please explain _____

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

_____

_____