Date: _____ Patient RT#: _____

First Name | MI | Last Name | ____/____/____ Date of Birth | Age

Address | Apt# | City | State | Zip | County of Residence

☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Secure e-mail ☐ Mail (to address above) *Check your preferred method of contact*

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

Social Security # (*optional*): _____ Sex: **M F** Marital Status: **S M W D**

Preferred Language: _____

Ethnicity: ☐-Hispanic/Latino ☐-Not Hispanic/Latino ☐-Do not want to provide ☐-Do not know

Race: ☐-American Indian or Alaska Native ☐-Asian ☐ Black or African American ☐-Native Hawaiian or Pacific Islander ☐-White

Employed: N Y Retired: N Y _____ Date Disabled: **N Y** _____ Date

Employer: _____ Occupation: _____

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice? _____ Yes _____ No

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital, SNF, Convalescent Home, or Hospice.

Name of Facility | Phone

Address | City | State | Zip

INSURANCE INFORMATION

Primary Insurance | Medical Group (HMO) | ID# | Group #

Name/Relation of Policy Holder | Social Security # of Policyholder | Date of Birth of Policyholder

Secondary Insurance | Medical Group (HMO) | ID# | Group#

Name/Relation of Policy Holder | Social Security # of Policyholder | ____/____/____ Date of Birth of Policyholder

Primary Care Physician | Phone

Referring Physician | Phone

EMERGENCY CONTACT

Name | Phone | Relationship

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Patient/Guardian Signature _____ **Date** _____

Patient Reported History

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____ DOB:_____

☐ Retrospective entry of previously completed form **(Research office only)**

Instructions: Please answer these questions as accurately as possible. This will help your physician evaluate your illness. All information is confidential and will not be released without your written permission.

List of Chronic Medical Illnesses or Problems (Type & Year Diagnosis)

Medical Illnesses/Problems	Year

Medical History:

Do you have a pacemaker or internal defibrillator?	☐ **Yes**	☐ **No**
Have you ever had hip surgery?	☐ **Yes**	☐ **No**

Surgeries, Procedures & Hospitalizations

Type of Procedures or Hospitalizations	Where	Year

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____ DOB:_____

Important: Prior Cancer Treatments

Have you ever had any radiation/cobalt treatments (including treatment for birthmarks, acne, cancer etc.?)
☐ Yes ☐ No
If Yes, where (name of institution) was this performed, what for, and when?

Did you receive Chemotherapy? ☐ Yes ☐ No
If Yes, what drugs?

Have you received hormone therapy for cancer? ☐ Yes ☐ No

Medication Name	Date

For Women: (Gynecological History)

Menarche (First Menstrual Period)(Age):_____ Last Menstrual Period (Date): _____ Age at menopause:_____

Pregnancies (Number): _____ Miscarriage (Number): _____ Deliveries (Number): _____

Are you or could you be pregnant? ☐ Yes ☐ No Age at first pregnancy? _____

Did you ever take hormones (i.e. estrogen, birth control pills, androgens, etc.)? ☐ Yes ☐ No

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

DOB:_____

Social History

Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes or other carcinogens? ☐ Yes ☐ No

What? _____ For how many years? _____

Family History

Relation	Age	Medical Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Comments:			

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____ DOB:_____

Medications

List the medications you are presently taking, including OTC, Vitamins and Supplements:

Prescription	Dosage	Frequency	For What?

Allergies (Drug, Food, Iodine etc...)

Do you have any allergies? ☐ Yes ☐ No

If Yes, what are you allergic to and what type of reaction do you get?

Name:_____ DOB:_____ MR/RT #_____

Review of systems - PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	YES	NO
Appetite	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Lethargy	☐	☐
Malaise	☐	☐
Night Sweats	☐	☐
Rigors/Chills	☐	☐
Weight Changes	☐	☐

EYES		
Blurred Vision	☐	☐
Double Vision	☐	☐
Teary eyes	☐	☐
Night Blindness	☐	☐
Sensitive to Light	☐	☐
Visual Difficulties	☐	☐

ENMT		
Difficulty Swallowing	☐	☐
Ear Pain	☐	☐
Nose Bleed	☐	☐
Esophagitis	☐	☐
Hearing difficulty	☐	☐
Mouth Dryness	☐	☐
Oral Bleeding	☐	☐
Sinus problems	☐	☐
Sputum Production	☐	☐
Mouth Sores	☐	☐
Altered Taste	☐	☐
Ringing in Ears	☐	☐

NECK	YES	NO
Masses	☐	☐
Muscle Weakness	☐	☐
Range of Motion	☐	☐
Pain/Swelling	☐	☐

BREASTS		
Breast Masses	☐	☐
Nipple Discharge	☐	☐
Nipple Inversion	☐	☐

INTEGUMENTARY	YES	NO
Abnormal Hair Loss	☐	☐
Blisters	☐	☐
Bruising	☐	☐
Facial Burning	☐	☐
Abnormal Nails	☐	☐
Photosensitivity	☐	☐
Dry/Itchy Skin	☐	☐
Rash /hives	☐	☐

CARDIOVASCULAR		
Arrhythmias	☐	☐
Chest Pain	☐	☐
Edema	☐	☐
Palpitations	☐	☐

REPIRATORY		
Cough	☐	☐
Shortness of breath	☐	☐
Hemoptysis	☐	☐
Hiccups	☐	☐
Chest Pain	☐	☐
Wheezing	☐	☐

GASTROINTESTINAL	YES	NO
Abdominal Pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Spitting up blood	☐	☐
Red blood in stool	☐	☐
Hemorrhoids	☐	☐
Black tarry stool	☐	☐
nausea/vomiting	☐	☐
pain/cramping	☐	☐
Feeling of fullness	☐	☐

MUSCULOSKELETAL	YES	NO
Arthritis	☐	☐
Bone Pain	☐	☐
Joint Pain	☐	☐
Muscle Weakness	☐	☐
Range of Motion	☐	☐

GENITOURINARY (M)	YES	NO
Burning with urination	☐	☐
Urinary Frequency	☐	☐
Blood in Urine	☐	☐
Impotence	☐	☐
Incontinence	☐	☐
Nocturia	☐	☐
Kidney Stones	☐	☐
Retrograde Ejaculation	☐	☐
Scrotal Swelling	☐	☐
Urgency	☐	☐
Urine Color Changes	☐	☐

NEUROLOGIC		
Disorientation	☐	☐
Dizziness	☐	☐
Headaches	☐	☐
Trouble Sleeping	☐	☐
Memory Loss	☐	☐
Neuropathy	☐	☐
Paralysis	☐	☐
Seizure	☐	☐
Sensory Problems	☐	☐
Stroke	☐	☐

PSYCHIATRIC		
Delusions	☐	☐
Hallucinations	☐	☐
Depression	☐	☐
Mood Swings	☐	☐

ENDOCRINE		
Diabetes	☐	☐
Hot flashes	☐	☐
Thyroid Disease	☐	☐

HEMATOLOGIC/LYMPHATIC		
Easy Bruising	☐	☐
Swollen Lymph Nodes	☐	☐

_____ Nurse Signature

Revised 6/16/14

_____ MD Signature

Southeast Regional Prostate Cancer Treatment Center

Request / Authorization for Release of Medical Records

I authorize Southeast Regional Prostate Cancer Treatment Center to release information from my medical records:

_____ _____

Patient's Name Date of Birth

2. Information to be released includes (please check):

_____ All medical information including psychiatric, alcohol and/or drug treatment, HIV and/or AIDS (if present)

_____ Only the following information: _____

_____

3. Information is to be released to (family member or friend):

Name _____

Relationship _____

Phone Number _____

I understand that consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

_____ _____

Patient's or Legal Representative's Signature Date

_____ _____

Relationship Witness

DOB: _____ MR/RT # _____

Southeast Regional Prostate Cancer Treatment Center

Patient Photograph Consent Form

I _____(self/wife/husband/child) understand that _____(name of patient) must have a photograph taken on initial consult for purposes of the chart. Photographs will be taken at the time of simulation and throughout the radiation process: for the purposes of showing correct positioning for the radiations therapist. I have read the above and give my consent.

Signed: _____ Date: _____

Witness: _____ Date: _____

DOB: _____ MR/RT # _____