

PLEASE TAKE A FEW MINUTES TO FILL OUT THIS QUESTIONNAIRE. WE UNDERSTAND SOME OF THE INFORMATION MAY BE INCLUDED IN OUR ELECTRONIC RECORDS HOWEVER WE WANT TO ENSURE YOUR RECORDS ARE COMPLETE AND UP TO DATE. THANK YOU FOR YOUR ASSISTANCE. –The Department of Radiation Oncology, Palo Alto Medical Foundation

|   |  |      |                      |                                    |  |
|---|--|------|----------------------|------------------------------------|--|
| <b>NAME</b>   |  |      | <b>TODAY'S DATE:</b> |                                    |  |
| <b>ALLERGIES TO MEDICATIONS – please list medication and reaction you had</b>       |  |      |                      |                                    |  |
| <b>PLEASE LIST YOUR CURRENT MEDICATIONS, INCLUDING VITAMINS/ANTIOXIDANTS/HERBS:</b> |  |      |                      |                                    |  |
| Name  |  | Dose | Times Per Day        | Name                               |  |
|   |  |      |                      |                                    |  |
|   |  |      |                      |                                    |  |
|   |  |      |                      |                                    |  |
|   |  |      |                      |                                    |  |
| <b>MEDICAL HISTORY</b>  |  |      |                      |                                    |  |
| Have you had radiation therapy before?  |  | Y N  | If yes →             | What part of the body was treated? |  |
|   |  |      |                      | Which facility?                    |  |
| Have you had or are you having chemotherapy?  |  | Y N  | If yes →             | When?                              |  |
| Have you had surgery?   |  | Y N  | If yes →             | Type of operation                  |  |
|   |  |      |                      | When?                              |  |
|   |  |      |                      |                                    |  |
|   |  |      |                      |                                    |  |
|   |  |      |                      |                                    |  |
| <b>DO YOU HAVE ANY OF THE FOLLOWING:</b>  |  |      |                      |                                    |  |
| Pacemaker   |  | Y N  | If yes →             | Date: _____                        |  |
| Kidney dysfunction/problems   |  | Y N  |                      | Date: _____                        |  |
| Diabetes  |  | Y N  |                      | Date: _____                        |  |
| High Blood Pressure   |  | Y N  |                      | Date: _____                        |  |
| Coronary Artery Disease   |  | Y N  |                      | Date: _____                        |  |
| Ataxia telangiectasia (Louis-Bar Syndrome)  |  | Y N  |                      | Date: _____                        |  |
| Xeroderma pigmentosa  |  | Y N  |                      | Date: _____                        |  |
| Lupus, Scleroderma, or Rheumatoid Arthritis   |  | Y N  |                      | Date: _____                        |  |
| Do you have any other medical illnesses?  |  | Y N  | If yes →             | Please describe:                   |  |
|   |  |      |                      |                                    |  |
| <b>SOCIAL HISTORY</b>   |  |      |                      |                                    |  |
| Please list occupation (or previous occupation if retired) :                        |  |      |                      |                                    |  |
| Have you ever smoked cigarettes?  |  | Y N  | If yes →             | Year started smoking: _____        |  |
|   |  |      |                      | Year stopped smoking: _____        |  |
|   |  |      |                      | Packs per day: _____               |  |
| Have you used any other tobacco products or other drugs?                            |  | Y N  | If yes →             | Please list type and dates used:   |  |
|   |  |      |                      |                                    |  |
| Do you drink alcohol?   |  | Y N  | If yes →             | How many drinks per day?           |  |
|   |  |      |                      |                                    |  |

| <b>FAMILY HISTORY</b>   |  |                      |                  |
|---|--|----------------------|------------------|
| Do you have any family with a history of cancer?<br><br>If so, please list:   | Relationship   | Cancer Type/Location | Age at Diagnosis |
|   |  |                      |                  |
| <b>REVIEW OF SYSTEMS</b>  |  |                      |                  |
| PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING   |  |                      |                  |
| Do you have any of the following?<br><br>GENERAL  | Recent weight change ♦ Muscle pain<br>Bone pain<br>Fatigue ♦ Fever   |                      |                  |
| Do you have any of the following?<br><br>NEURO/PSYCH  | Weakness ♦ Night Sweats ♦ Loss of appetite<br>Headaches ♦ Dizziness ♦ Memory loss<br>Local weakness/paralysis ♦ Fainting<br>Seizures ♦ Stroke ♦ Tingling/Numbness<br>Nervousness ♦ Mood change ♦ Tension<br>Depression |                      |                  |
| Have you had any problems with your skin or hair?<br><br>INTEGUMENTARY  | Rashes ♦ Lumps ♦ Lupus ♦ Scleroderma<br>Skin color change ♦ Change in hair/nails<br>Change in size/color of moles  |                      |                  |
| Have you had any problems with your eyes/vision?<br><br>Have you had any problems with your ears/hearing?<br><br>VISION/HEARING | Recent vision change ♦ Blurred/double vision<br>Pain ♦ Cataracts<br><br>Recent hearing change ♦ Ringing in ears<br>Vertigo ♦ Earaches  |                      |                  |
| Have you had any problems with your nose or sinuses?<br><br>ENT   | Nasal stuffiness ♦ Nosebleeds<br>Sinus trouble ♦ Persistent nasal drainage   |                      |                  |
| Have you had any problems with your mouth or throat?<br><br>Have you had any problems with your neck?<br><br>ENT                | Dental problems ♦ Sore throats ♦ Hoarseness<br>Bleeding gums ♦ Pain<br><br>Lumps ♦ Swollen glands ♦ Pain   |                      |                  |
| Have you had any problems with your breasts?<br><br>MAMMO   | Lumps ♦ Nipple discharge or bleeding ♦ Pain  |                      |                  |
| Have you had any problems with your breathing/lungs?<br><br>RESPIRATORY   | Cough ♦ Coughing blood ♦ Bronchitis<br>Pneumonia ♦ Shortness of breath ♦ Wheezing<br>Emphysema ♦ TB<br>Excess sputum production ♦ Pain   |                      |                  |

|   |  |
|---|--|
| <p>Have you had any heart or blood vessel problems?</p> <p style="text-align: right;">CARDIOVASCULAR</p>                        | <p>High blood pressure ♦ Heart attack ♦ Chest pain<br/> Palpitations ♦ Rheumatic fever<br/> Waking at night w/shortness of breath<br/> Leg or ankle swelling ♦ Calf/leg cramps<br/> Swollen blood vessels in legs</p>                                      |
| <p>Have you had any muscle or bone problems?</p> <p style="text-align: right;">MUSCULOSKELETAL</p>                              | <p>Joint pain ♦ Joint stiffness ♦ Joint swelling<br/> Limited joint movement<br/> Muscle pain/cramps ♦ Muscle weakness<br/> Bone pain ♦ Bone deformity<br/> Recent trauma (fracture, sprain, dislocation)<br/> Other muscle/bone inflammatory problems</p> |
| <p>Have you had any problems with eating, digestion, or the bowel?</p> <p style="text-align: right;">GASTROINTESTINAL</p>       | <p>Difficulty swallowing ♦ Indigestion<br/> Nausea ♦ Vomiting<br/> Diarrhea ♦ Constipation<br/> Recent change in bowel habits<br/> Ulcers ♦ Colitis ♦ Hernias<br/> Other digestive problems (gallbladder, hepatitis, certain food intolerances, etc.)</p>  |
| <p>Have you had any problems with your urinary function?</p> <p style="text-align: right;">GU</p>                               | <p>Increased frequency ♦ Pain with urination<br/> Sudden urge ♦ Uncontrolled bladder/incontinence<br/> Urination at night ♦ Decreased stream<br/> Blood in urine</p>   |
| <p><b>MEN:</b> Have you had any problems with your penis/testicles or groin area?</p> <p style="text-align: right;">GU MALE</p> | <p>Discharge/sores on penis ♦ Hernias<br/> Testicular pain or masses ♦ Sexual difficulties</p>   |
| <p><b>WOMEN:</b> Have you had any vaginal or menstrual problems?</p> <p style="text-align: right;">GU FEMALE</p>                | <p>Irregular or absent periods<br/> Postmenopausal bleeding<br/> Pain/bleeding with intercourse ♦ Sexual difficulties<br/> Abnormal blood flow b/w periods<br/> Vaginal discharge</p>  |
| <p>Do you have any of the following?</p> <p style="text-align: right;">ENDOCRINE/HEMATO</p>                                     | <p>Thyroid trouble ♦ Heat or cold intolerance<br/> Excessive thirst ♦ Hunger ♦ Sweating<br/> Anemia ♦ Easy bruising or bleeding<br/> Bleeding gums<br/> Past blood transfusions and reactions</p>  |