SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM

Patient Name: _____ _____
Last First M.I. Today's Date

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

☐ Yes ☐ No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____ Are you pregnant now ☐Y ☐N

Hysterectomy: ☐Y ☐N Ovaries removed ☐Y ☐N

Hormone use: ☐Y ☐N Oral contraceptive use ☐Y ☐N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Circle One: Male OR Female

Last mammogram: _____ Last Prostate exam: _____

Last Pap smear: _____ Last PSA screening: _____

Last colonoscopy: _____ Last Flu vaccine: _____

Last bone density scan: _____ _____

Last pneumonia vaccine: _____ _____

SOCIAL HISTORY

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐Y ☐N				
Tobacco:	☐Y ☐N				
Caffeine:	☐Y ☐N				
Recreational Drugs:	☐Y ☐N				

FAMILY HISTORY: Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			☐Y ☐N	Brothers:			☐Y ☐N
Father:			☐Y ☐N				☐Y ☐N
Grandmother (P):			☐Y ☐N				☐Y ☐N
Grandfather (P):			☐Y ☐N	Sisters:			☐Y ☐N
Grandmother (M):			☐Y ☐N				☐Y ☐N
Grandfather (M):			☐Y ☐N				☐Y ☐N
				Children:			☐Y ☐N
							☐Y ☐N
							☐Y ☐N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	☐Y	☐N
Poor Energy Level	☐Y	☐N
Fever	☐Y	☐N
Chills	☐Y	☐N
Night Sweats	☐Y	☐N

Eyes		
Double Vision	☐Y	☐N
Vision Loss	☐Y	☐N
Flashing Lights	☐Y	☐N

ENT/Mouth		
Ringing in Ears	☐Y	☐N
Hearing Loss	☐Y	☐N
Oral Ulcers	☐Y	☐N
Mouth Pain	☐Y	☐N
Sore Throat	☐Y	☐N
Difficulty Swallowing	☐Y	☐N
Hoarseness	☐Y	☐N

Cardiovascular		
Chest Pain	☐Y	☐N
Palpitations	☐Y	☐N
Fainting Spells	☐Y	☐N
Leg Swelling/Pain	☐Y	☐N
Arm Swelling/Pain	☐Y	☐N

Respiratory		
Cough	☐Y	☐N
Wheezing	☐Y	☐N
Shortness of Breath	☐Y	☐N
Coughing Blood	☐Y	☐N
Pain with Breathing	☐Y	☐N

Breast		
Mass	☐Y	☐N
Pain	☐Y	☐N
Nipple Discharge	☐Y	☐N
Change in Size	☐Y	☐N
Change in Shape	☐Y	☐N

Gastrointestinal		
Nausea	☐Y	☐N
Vomiting	☐Y	☐N
Jaundice	☐Y	☐N
Abdominal Pain	☐Y	☐N
Maroon/Black Stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Vomiting Blood	☐Y	☐N
Difficulty Swallowing	☐Y	☐N

Urinary		
Painful Urination	☐Y	☐N
Blood in Urine	☐Y	☐N
Increased Frequency	☐Y	☐N
Loss of Control	☐Y	☐N
Impotence	☐Y	☐N

Gynecological		
Vaginal Discharge	☐Y	☐N
Pelvic Pain	☐Y	☐N
Abnormal Bleeding	☐Y	☐N

Musculoskeletal		
Muscle Pain	☐Y	☐N
Spine Tenderness	☐Y	☐N
Swollen Joints	☐Y	☐N
Joint Redness	☐Y	☐N
Bone Pain	☐Y	☐N

Skin		
Rash	☐Y	☐N
Nodules	☐Y	☐N
Itchiness	☐Y	☐N
Lesions	☐Y	☐N

Neurological		
Confusion	☐Y	☐N
Seizures	☐Y	☐N
Fainting Spells	☐Y	☐N
Tremors	☐Y	☐N
Speech Change	☐Y	☐N
Headache	☐Y	☐N
Abnormal Gait	☐Y	☐N
Weakness	☐Y	☐N
Sensory Change	☐Y	☐N

Psychiatric		
Anxiety	☐Y	☐N
Depression	☐Y	☐N

Endocrine		
Excessive Urine	☐Y	☐N
Excessive Thirst	☐Y	☐N
Hot Flashes	☐Y	☐N
Heat/Cold Intolerance	☐Y	☐N

Hematological		
Nose Bleeds	☐Y	☐N
Bleeding Gums	☐Y	☐N
Easy Bruising	☐Y	☐N

Lymphatic		
Enlarged Lymph Nodes	☐Y	☐N
Swelling in Arms/Legs	☐Y	☐N

Radiation/Chemo History:

Previous Radiation Therapy: ☐ Yes ☐ No If yes, where?_____
Previous Chemotherapy: ☐ Yes ☐ No If yes, where?_____

Patient Preferences:

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? ☐ Yes ☐ No
Do you have a durable power of attorney or a living will? ☐ Yes ☐ No
Do you have a current Advanced Directive? ☐ Yes
☐ No
Are there any language barriers that the staff needs to be aware of? ☐ Yes ☐ No
Do you feel unsafe or threatened by anyone? ☐ Yes ☐ No
Do you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No

REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? _____

Have you ever accessed the VA for any services? Yes or No If so, what services did you use?
_____

Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.

_____
_____
_____
_____
_____

Patient Signature: _____

Patient Printed Name: _____

Date: _____