M5002
Rev. 9/09

DUKE UNIVERSITY HEALTH SYSTEM

DEPARTMENT OF RADIATION ONCOLOGY PATIENT INFORMATION FORM

Addressograph

Name
History number (inpatient)
Birthdate (clinics and PDC)

Date: ________ Current Age: _____

Emergency Contacts (that we have your permission to call if an emergency arises):

Name/relationship: ______________________ Phone number: ______________________

Name/relationship: ______________________ Phone number: ______________________

Primary Doctor and Referring Doctor/s:

Name: ______________________ Address: ______________________

City: ______________ State: ____ Zip: ______ Phone number: ____________

Name: ______________________ Address: ______________________

City: ______________ State: ____ Zip: ______ Phone number: ____________

Name: ______________________ Address: ______________________

City: ______________ State: ____ Zip: ______ Phone number: ____________

Adverse Food and/or Drug Reactions (Including Latex): ______________________

____

Advance Directives:

Do you have a North Carolina Advance Directive or Living Will? ☐ Yes ☐ No
Copy available? ☐ Yes ☐ No
If you do not have a copy, do you want to complete a new one? ☐ Yes ☐ No
If you do not have an advance directive, do you want to complete one? ☐ Yes ☐ No

Psychosocial Information:

Occupation (if retired, former occupation): ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Situation: ☐ Alone ☐ Family/friend ☐ Other ______________

Educational Information:

What language do you speak? ☐ English ☐ Other ______________

What language do you read? ☐ English ☐ Other ______________

Highest grade of school completed? 1 2 3 4 5 6 7 8 (Elementary) 1 2 3 4 (High School) 1 2 3 4 (College) Masters Doctorate

How do you learn best? ☐ Written ☐ Listening ☐ Visually ☐ All methods

Do you wear glasses? ☐ Yes ☐ No Do you use a hearing aid? ☐ Yes ☐ No

Nutritional Status

Height _____ feet _____ inches Current weight ______ pounds Weight 6 mos. ago ______pounds

Food intake: ______ Normal ______Little solid food ______Only liquids ______Feeding tube

______ Nutritional supplements only Type and how much ______________________

Would you like to see a dietitian? ☐ Yes ☐ No

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Current Medications (prescribed, over the counter, herbals, vitamins, and study medications):

Drug Name	Dose	Frequency	Reason for Taking

Past Illnesses/Surgeries and/or Chronic Medical Problems:

Type of Illness	Year

Past Cancers and Cancer Treatments (Surgery, Chemotherapy and/or Radiation):

Cancer Treatment	Year

Family History

Relationship	Age	Medical Problems	If deceased, age and cause of death
Father			
Mother			
Brothers: #			
Sisters: #			
Children: #			

Other relatives with cancer/type of cancer: ____________________

Review of Systems:
Please circle any of the symptoms below that you have had in the last six months:

Headaches	Seizures	Loss of balance	Dizziness
Eye trouble, double vision	Hearing loss	Sinusitis or postnasal drip	Difficulty swallowing
Change in appetite	Hoarseness/change in voice	Sores in mouth or lips	Sore mouth/throat
Cough	Shortness of breath	Coughing up blood	Changes in bowel habits
Rectal bleeding	Hemorrhoids or irritation	Foul smelling urine	Blood in urine __
Pain/burning with urination	Frequency of urination	Impotence or difficulty with sex	Night sweats/fevers
Marked fatigue or weakness	Changes in sleeping pattern	Mood changes/depression	Bone or joint pain
Chest pain (s)	Easy bruising or unusual bleeding	Palpitations or heart fluttering	Skin rash or itching
Numbness/tingling	Nausea	Vomiting	Pain ______________
Decrease in size or force of urine stream		Enlarged or swollen lymph glands	

Tobacco Use
Type: ______________________ How much per day? ______________________
How many years? _____________ If you have quit, when? ____________________

Alcohol Use
Type: ______________________ How much per day? ______________________
How many years? _____________ If you have quit, when? ____________________

Functional Capacity: Over the past month, how would you rate your activity level?
_____ Normal with no limitations
_____ Not your normal self, able to be up and about with fairly normal activities
_____ Not feeling up to most things, but in bed less than half the day
_____ Able to do little activity and spend most of the day in bed or chair
_____ Pretty much bedridden, rarely out of bed

Do you need to see a social worker regarding any of the following? ☐ Yes ☐ No
____ Lodging _____ Equipment needs (home oxygen, walker, hospital bed, etc.)
____ Transportation _____ Medications _____ Personal matters (coping/stress)

Are you currently receiving home health care? ☐ Yes ☐ No

If yes, name of agency ____________________________

Reproductive History (Females Only):

Age when your periods began? ______ Date of your last period? _______ Date of last PAP smear _______

Total pregnancies you've had? _______ Age at first birth? ____________

How many children born alive? ______ Miscarriages and/or abortions? _______

Did you have any medical problems associated with pregnancy? ☐ Yes ☐ No
Any other gynecological illnesses? ☐ Yes ☐ No
Are you or could you be pregnant? ☐ Yes ☐ No

Have you used post-menopausal hormones? ☐ Yes ☐ No Dates: ________ What kind: ________
Have you ever used birth control pills? ☐ Yes ☐ No Dates: What kind: ______________

Date of last mammogram _________ Do you have a history of benign breast problems? ☐ Yes ☐ No

Previous biopsies? ☐ Yes ☐ No If yes, dates: ____________

Do you perform self-breast exams regularly? ☐ Yes ☐ No

Patient Signature: ______________________________ **Date/time:** ___________

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Healthcare Personnel Section

Problem List:

_______________ Is this problem? ☐ Acute ☐ Chronic ☐ History of

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_______________ Is this problem? ☐ Acute ☐ Chronic ☐ History of

Does the patient need a referral to the following:

Referral to:		Date Initiated	Person Contacted	Signature
Dietitian	Y or N			
Interpreter	Y or N			
Social Worker	Y or N			
Pharmacy Patient Asst.	Y or N			

Nurse Signature: _______________ Date/time: _______________

Physician Signature: _______________ Date/time: _______________