

Weight today _____ with clothes & shoes. Per Dr. _____ the Side Effect sheet given

Radiation Medical Group, Inc.
Patient Medical Information Form

Form must be completed in ink

Patient Name _____ Cancer Type _____

Doctor who referred you to Radiation Medical Group _____

Your Primary Care or Family Doctor _____

Your occupation: _____

Cancer Operations, including biopsies - *please list type & date(s)*

Chemotherapy: Yes _____ No _____ *If yes, please list approximate date started & completed*

Briefly describe any symptoms you feel may be related to your cancer

Past **Cancer** History: Yes _____ No _____ *If yes, please describe*

History of Previous Radiation Therapy: Yes _____ No _____ *If yes, please list approximate date(s) and body area treated*

Past **Medical** History:

Past **Surgical** History: *Please List all previous Operations and include dates*

Medications - *Please list all prescribed drugs and, if known, dose & number of times taken per day on the attached form.*

Known Allergies to Medications: Yes _____ No _____ *If yes, to what?* _____

Family History of Cancer: Yes _____ No _____ *If yes, please describe which family member(s) and what type(s) of cancer*

Personal Habits - History of Tobacco use: Yes _____ No _____ *If yes, please describe maximum number of packs smoked per day, number of years of use and, if discontinued, when?*

Personal Habits - History of Alcohol use: Yes _____ No _____ *If yes, please describe number of alcoholic drinks per day, number of years of use and, if discontinued, when?*

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Radiation Medical Group, Inc.
Patient Medical Information Form, continued

Medication List (Please complete in full for our records)

<u>Medication</u>	<u>Dose</u>	<u>Times Taken Daily</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		
11. _____		
12. _____		

Gynecological (Females only)

Are you pregnant? Yes No

Number of children: _____

Number of pregnancies: _____ Live births _____ Other _____

Age of 1st pregnancy: _____

Did you breast feed your children? no yes/How long _____

Age of first menstrual period: _____ Last menstrual period: _____

Last pelvic exam/PAP: _____

Have you used birth control pills Yes No How many years? _____

Hormones taken Name _____ How long _____

Hysterectomy When _____ Why? _____

Last mammogram/date _____

Do you do self breast exams? yes no

Bra cup size _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Patient Signature _____ Date _____