97 Health Park Blvd., St. Augustine, FL 32086

PATIENT QUESTIONNAIRE

PATIENT INFORMATION		
Patient Information:	Date of Birth:	Date:
Referring Physician:	Primary Care Physician:	
REASON FOR VISIT		

CURRENT SYMPTOMS

Please mark with an (X) any illness or medical problems you have, or have had, within the past month.

Symptoms	Y	N	Symptoms	Y	N	Symptoms	Y	N
Weakness			Cough up Blood			Headaches		
Tiredness			Wheezing			Blackouts		
Poor Appetite			Shortness of Breath			Dizziness		
Weight Loss			**CADIOVASCULAR**			Loss of Balance		
Fever			Chest Pain			Numbness		
Night Sweats			High Blood Pressure			**PSYCHIATRIC**		
BREASTS			Irregular Heartbeat			Nervousness		
Lumps			**GASTROINTESTINAL**			Depression		
Pain			Nausea			Difficulty Sleeping		
Discharge			Vomiting			Stress		
EYES, EARS, NOSE & THROAT			Diarrhea			**MUSCULOSKELETAL**		
Change in Vision			Constipation			Painful Joints		
Difficulty Hearing			Abdominal Pain			Muscle Pain		
Nose Bleeds			Heartburn			Back Pain		
Hoarseness			Bright Red Blood in Stools			**BLOOD**		
URINARY			Black Stools			Anemia		
Pain or Burning when Urinating			Change in Bowel Habits			Easy Bruising		
Frequent Urination			**SKIN**			Prolonged Bleeding		
Kidney Stones			Itching			Blood Clots		
Blood in Urine			Rash			Transfusions		

Pain Scale: Please rate your pain from 0 to 10   0 = No Pain   10 = Very Severe

"I rate my pain as ____"   Location of Pain: ___________________________

Previous radiation treatments? Yes___ No ___   Where? _________________________ Dates: __________

Pacemaker? Yes ___ No ___   Defibrillator? Yes ____ No ____

PATIENT HISTORY QUESTIONNAIRE

Patient Name: ____ Date of Birth: _________________

PAST MEDICAL HISTORY Please circle any illnesses or medical problems you have now or have had in the past and indicate the year each started. If this has occurred within the last three (3) years add an asterisk (*).					
ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Pneumonia		High Blood Pressure		Neurologic Disorders/Stroke	
Diabetes		Liver Disease		Emotional Disorders	
Blood Disorders		Thyroid Disease		HIV positive/ AIDS	
Heart Disease (CHF, MI, Atrial Fibrillation)		Cancer		COPD	
Kidney Disease		Skin Disease		Crohn's Disease or Ulcerative Colitis	
Lupus		Scleroderma		Arthritis/Chronic Pain	
Pulmonary Embolism/Clot		Hemorrhoids		Stomach Ulcers/ GI Bleeding	
Other:					

IMMUNIZATIONS If yes, provide approximate year received.	
Influenza (Flu) Yes ____ No____	Pneumococcal Yes____ No____
Other Immunizations:	

SURGERIES/HOSPITALIZATIONS/INJURIES List all hospitalizations, operations, tests, procedures and severe injuries.		
Date	Type of Operation, Test, Procedure, or Severe Injury.	Physician & Medical Facility

PREVIOUS RADIATION TREATMENTS		
Area of Treatment	Date of Test	Medical Facility

SOCIAL HISTORY					
Marital Status:			Occupation: Working ___ Retired _____ Not Working ___		
	Y	N	Type	How much?/How often?	Quit?
Recreational Drug Use					
Tobacco					
Alcohol					
Other					

RECENT DIAGNOSTIC TESTS

TEST	DATE OF TEST	MEDICAL FACILITY
CAT Scans/ X-Rays:		
PET Scans/ Bone Scans:		
Ultrasound:		
MRI:		
Colonoscopy:		
Mammogram:		
Other:		

FAMILY HISTORY

List any blood relative who has ever been diagnosed with cancer or a blood disorder.

Relationship	Type of Cancer or Blood Disorder	Age at Diagnosis	Deceased? Y or N

FOR WOMEN ONLY

Onset of Menstruation:		Number of Live Births:	
Date of Last Menstrual Cycle:		Abnormal Menstruation?	Y or N
Number of Pregnancies:		Hot Flashes?	Y or N
Age at First Pregnancy:		Age at Menopause:	
Other:			
Hormone Replacement Therapy:			

Other: ____

____

Patient Signature: ____ Date: _________________ Time: ________

Physician Signature: ____ Date: _________________ Time: ________

FLAGLER RADIATION ONCOLOGY

Patient Name: ____ Date of Birth: ____________

CURRENT MEDICATION/SUPPLEMENTS AND ALLERGIES PLEASE BE SPECIFIC! If the start and stop date are unknown, please give the approximate year and month.		
MEDICATION	**DOSE**	**FREQUENCY**
ALLERGIES: (Ex. Penicillin)	REACTION: (Ex. difficulty breathing)	Severe ___ Moderate ___ Mild ___
		Severe ___ Moderate ___ Mild ___
		Severe ___ Moderate ___ Mild ___
		Severe ___ Moderate ___ Mild ___
		Severe ___ Moderate ___ Mild ___
		Severe ___ Moderate ___ Mild ___

PHARMACY INFORMATION:

Pharmacy Name: ____ Phone Number: __________

Address: ____ Fax Number: ________________________

City: _____________________________________ State: _____________ Zip: __________________