RADIATION ONCOLOGY CARE
AT MERIDIAN PARK

Patient Name: _____ DOB: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone _____

Referring Physician: _____ Primary Physician: _____

Other Physicians Caring for you: _____

Medical Conditions

Recent and Upcoming Appointments and Tests (ex: Scans, Biopsies, Consults, Etc.)

Appointment or Test	When	Where

6489 S.W. Borland Rd. Tualatin, OR 97062
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Patient Name: _____ Date: _____ DOB: _____

Past Surgeries/Procedures	Year	Surgeon	Hospital

Have you had cancer in the past? Yes No - Please describe type, dates, etc. _____

Past or Present Chemotherapy	Month/Year	Physician/Clinic

Past Radiation Therapy	Month/Year	Physician/Clinic

Allergies

Do you have any medication allergies? Yes No - Please list below

Do you have an allergy to iodine or contrast? Yes No - Please list below

Allergen	**Reaction**

Preferred Pharmacy	**Pharmacy Phone Number**

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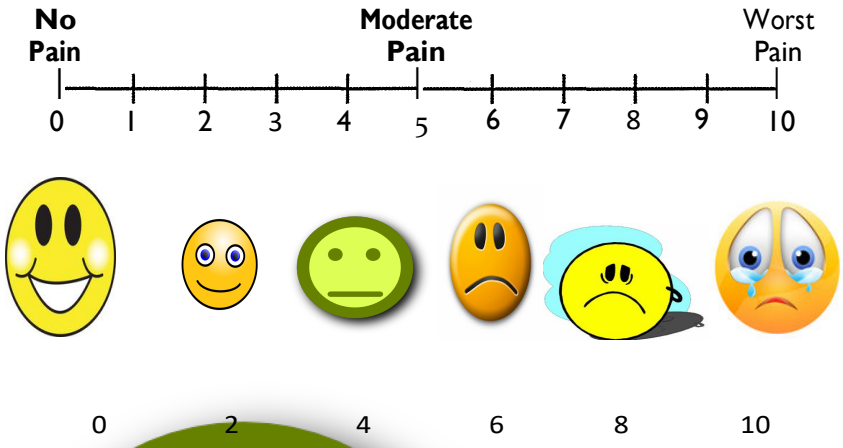
PATIENT NAME: _____ Date: _____ DOB: _____

Medications - Please list any medications you are taking at this time (include vitamins and nutritional supplements)

Medications		Dose	How Often

Pain Rating



What is your current pain level? _____

Describe the pain and its location:

_____

_____

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Patient Name: _____ Date: _____ DOB: _____

Review of Systems - Check any symptoms that you currently have or have had in the last 6 months

Constitution		**Eyes**		**Muscular**		**Cardiovascular**	
Activity Change		Eye Discharge		Joint Pain		Chest Pain	
Appetite Change		Eye Itching		Joint Swelling		Leg Swelling	
Chills		Eye Pain		Gait Problem		Palpitations	
Night Sweats		Eye Redness		Back Pain			
Fatigue		Sensitive to Light		Muscle Pain		**Neurological**	
Fever		Visual Disturbance		Neck Pain		Dizziness	
Severe Weight Loss				Neck Stiffness		Facial Drop	
		Respiratory				Headaches	
HEENT		Sleep Apnea		**GU**		Light-headedness	
Congestion		Chest Tightness		Difficulty Urinating		Numbness	
Dental Problems		Choking		Incontinence		Seizures	
Drooling		Cough		Painful Urination		Speech Difficulties	
Ear Discharge		Short of Breath		Kidney/Flank Pain		Fainting	
Ear Pain		Wheezing		Urinary Frequency		Weakness	
Facial Swelling				Genital Sores			
Hearing Loss		**Endocrine**		Blood in Urine		**Hematologic**	
Mouth Sores		Cold Intolerance		Urgency		Swollen Lymph Nodes	
Nosebleeds		Heat Intolerance		Urine Decreased		Bruise/Bleeds Easily	
Postnasal Drip		Abnormally Thirsty					
Runny Nose		Abnormally Hungry		**GU-Female Only**		**Psychiatric**	
Sinus Pressure				Pelvic Pain		Agitation	
Sneezing		**GI**		Menstrual Problems		Behavior Problems	
Sore Throat		Bloating		Vaginal Bleeding		Confusion	
Ringing in the Ears		Abdominal Pain		Vaginal Discharge		Hallucinations	
Trouble Swallowing		Anal Bleeding				Hyperactive	
Voice Change		Blood in Stool		**GU-Male Only**		Decreased Concentration	
		Constipation		Penile Pain		Anxiety	
Skin		Diarrhea		Penile Swelling		Nervous	
Jaundice		Nausea		Penile Discharge		Self-Injury	
Pallor		Vomitting		Testicular Pain		Sleep Disturbance	
Rash				Scrotal Swelling		Suicidal Ideas	
Wound		**Immune System**				Depression	
		HIV Positive					
		AIDS					

Are there any other symptoms or problems that you believe are important? _____

_____

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PATIENT NAME: _____Date: _____ DOB: _____

Social History:

Occupation: _____ Retired: Yes No

Marital Status: Single Married Separated Divorced Widowed

Children:

# of Girls: _____ Ages: _____

# of Boys: _____ Ages: _____

Do you have a support System (friends, family, counselor, etc?): Yes No

Who lives with you? _____

Do you currently Drink Alcohol: Yes No Did you drink in the Past?: Yes No

How Often do you drink?: Occasionally Socially Moderately (Drinks/day_____)

Do you Currently Use Tobacco?: Yes No When Did you stop?_____

How Often do you smoke?: _____ Packs/day for _____ years Do you wish to quit?: Yes No

Family History:

	Living? Yes or NO	Ages	Important Medical History
Father			
Mother			
Brothers (total #____)	# Living_____ # Deceased		
Sisters (total # ____)	# Living_____ # Deceased_____		
Grandfather (Paternal)			
Grandfather (Maternal)			
Grandmother (Paternal)			
Grandmother (Maternal)			

Male Non-Prostate Patients: Please Complete Page 6
Prostate Patients: Please Complete Page 6 & 7
Female Patients: Please Complete Page 8

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MALE PATIENTS ONLY

	Not at all	Less than 1 Time in 5	Less than ½ the Time	About ½ the time	More than ½ the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **Total: _____**

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?							

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PROSTATE PATIENTS ONLY

Circle the number of the response that **best describes** your own situation over the past **6 MONTHS.**

		Very Low	Low	Moderate	High	Very High
How do you rate your confidence that you could get and keep an erection?		**1**	**2**	**3**	**4**	**5**
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	**No Sexual Activity**	**Almost Never or Never**	**A Few times (Much less than ½ the time)**	**Sometimes (about ½ the time)**	**Most times (Much More than ½ the time**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (Entered) your partner?	**Did not Attempt Intercourse**	**Almost Never or Never**	**A Few times (Much less than ½ the time)**	**Sometimes (about ½ the time)**	**Most times (Much More than ½ the time**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**Did not Attempt Intercourse**	**Extremely Difficult**	**Very Difficult**	**Difficult**	**Slightly Difficult**	**Not Difficult**
	0	**1**	**2**	**3**	**4**	**5**
When you attempted sexual intercourse, how often was it satisfactory for you?	**Did not Attempt Intercourse**	**Almost Never or Never**	**A Few times (Much less than ½ the time)**	**Sometimes (about ½ the time)**	**Most times (Much More than ½ the time**	**Almost Always or Always**
	0	**1**	**2**	**3**	**4**	**5**

Add the score for each number above and write the total in the space to the right. **Total: _____**

Are there any other things you would like us to know or that you believe are important to your medical care_____

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FEMALE PATIENTS ONLY

Is there a possibility you could be pregnant? Yes No

Menopause? Yes No Date of most recent menstrual period_____

Number of pregnancies? ____

Did you breast feed? Yes No How many children and for how long? _____
Date of last mammogram?_____ Date of most recent PAP smear? _____

Have you ever taken birth control pills? Yes No - How long? _____

Have you ever taken hormone medications (estrogen)? Yes No - Why type for how long? _____

_____

Are there any other things you would like us to know or that you believe are important in your medical care?

_____

_____

_____

_____

_____

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Patient Name: _____Date: _____ DOB: _____

Ethnicity: (Please Choose One Category)

_____ American Indian	**_____ Chinese**	**_____ English**	**_____Eskimo**
_____ French	**_____French Canadian**	**_____ German**	**_____ Hawaiian Islander**
_____ Hispanic/Latino	**_____ Irish**	**_____ Italian**	**_____ Japanese**
_____ Mediterranean	**_____ Polish**	**_____ Pt Declined**	**_____ Russian**
_____ Samoan	**_____ Scottish**	**_____ Welsh**	

RACE:

What is your race (Please choose One catagory);

____American Indian or Alaska Native	**_____Asian**	**____Black or African American**
____Pacific Islander	**_____Pt Declined**	**_____ White**