Medical History Form

Radiation Oncology Department

Carol G. Simon Cancer Center

Morristown Medical Center

Patient's Name: _____ Date of Birth:_____

Reason for Visit: _____ Date of Visit: _____

Have you had any prior treatment or evaluation for this problem? __ yes __no

If yes, what type of treatment/evaluation?_____

_____

Who is your referring Physician(s): _____

Medical History: Please check ( ) if you have or have had any of the following conditions:

___Heart Disease	___Hepatitis/Liver Disease	___Tuberculosis(TB)
___Emphysema (COPD)	___Stomach or intestinal disease	___MRSA
___Diabetes	___Neurological disorder	___ Psychological Disorders
___Kidney Disease	___HIV/AIDS	___ Joint Pain/swelling
___High Blood Pressure	___Eye Disorders	___ Back pain
___Bleeding Disorder	___Chest pain/angina	___ Other _____
___Ears/Nose/Mouth/Throat problems		_____

Have you ever been diagnosed with or treated for cancer? __yes __no

If yes, what type of cancer? _____

_____

What type of treatment have you received? (Ex: surgery, chemotherapy, previous radiation therapy?

_____

_____

_____

Medical History Form (Continued)

Surgical History: Have you had surgery before? __yes __no

If yes, what type and when? _____
_____
_____
_____

Family History: Is there any cancers that run in your family?
_____
_____

Have you had any genetic testing? __yes __no

If so, what was the result of the genetic testing? _____

Social History: Do you currently smoke or have you smoked in the past? __yes __no

How many packs per day? _____ For how long? _____ How long ago did you quit? _____

Do you currently use alcohol or have you used alcohol in the past? __yes __no

How many drinks per day? _____ For how long? _____ How long ago did you quit? _____

Have you or do you use recreational drugs? __yes __no

Allergies: Are you allergic to medications, iodine, or shellfish? __yes __no

If yes, which? _____

Are you allergic to any intravenous contrast (such as for a CT scan or MRI)? __yes __no

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

(if patient is a minor)

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Radiation Oncology Department
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