

Radiotherapy Associates of Upstate New York

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FAMILY PHYSICIAN

REFERRING PHYSICIAN

Name (Last, first & middle) _____ Date of Birth _____ Telephone # _____ Social Security Number _____

DATE _____
Please answer each question. If you are unable to answer any of the questions, please circle the question and call it to the attention of the examining doctor.

YOUR AGE: _____ THE FOLLOWING CONCERNS THE PERIOD BETWEEN YOUR LAST PHYSICAL EXAMINATION AND THIS ONE.
PLACE AN "X" IN THE APPROPRIATE COLUMN.

1. HAVE YOU HAD -

CARDIOVASCULAR	No	Seldom	Frequent	MISCELLANEOUS	No	Seldom	Frequent
SHORTNESS OF BREATH WITH EXERTION				FEVER			
ANKLE SWELLING				CHILLS			
HIGH BLOOD PRESSURE				NIGHT SWEATS			
RAPID HEART BEAT				HEADACHES			
IRREGULAR HEART BEAT				INSOMNIA			
DIZZINESS				NERVOUSNESS			
FAINING SPELLS				IRRITABILITY			
CHEST PAIN OR PRESSURE				MORNING TIREDNESS			
LEG CRAMPS				DEPRESSION			
RESPIRATORY				GENITOURINARY:			
COUGH				BACK PAIN			
COUGHED UP BLOOD				FREQUENT URINATION			
HOARSENESS				PAINFUL URINATION			
SORE THROATS				PAIN IN TESTICLES			
SNEEZING				BLOODY OR OTHER DISCHARGE			
HAY FEVER				LOSS OF SEXUAL POTENCY			
NOSE BLEEDS				MUSCULO-SKELETAL			
CHEST PAIN				ARTHRITIS			
ASTHMA OR WHEEZING				MUSCLE PAIN OR CRAMPS			
PNEUMONIA				PAINFUL JOINTS			
GASTROINTESTINAL				LAMENESS			
INDIGESTION				BACKACHES			
ABDOMINAL PAIN OR CRAMPS				WEAKNESS			
CONSTIPATION				SKIN			
DIARRHEA				ULCERATIONS			
BLOOD IN BOWEL MOVEMENT				ITCHING			
BLACK BOWEL MOVEMENT							
INCREASED APPETITE							
INCREASED THIRST							
DECREASED APPETITE							
NAUSEA AND VOMITING							
DIFFICULTY SWALLOWING							

WHAT MEDICATIONS DO YOU CURRENTLY TAKE?

ARE YOU RIGHT-HANDED ☐ LEFT HANDED ☐

ALLERGIES:

SURGICAL HISTORY TO PRESENT YEAR AND TYPE OF SURGERY.

ANY PRIOR HISTORY OF RADIATION
THERAPY, HORMONE OR CHEMOTHERAPY?

FEMALE AGE OF FIRST MENSES AGE OF MENOPAUSE NATURAL SURGICAL HISTORY MENSTRUAL IRREGULARITY NUMBER OF TIMES PREGNANT NUMBER OF LIVE BIRTHS AGE AT FIRST DELIVERY HORMONES DURING MENOPAUSE VAGINAL BLEEDING CURRENTLY	3. DOES YOUR FAMILY HAVE A HISTORY OF	YES	NO
	DIABETES		
	GOUT		
	HIGH BLOOD PRESSURE		
	HEART ATTACKS		
	STROKES		
	TB		
	CANCER		
		IF CANCER IS <input checked="" type="checkbox"/> YES, LIST FAMILY MEMBERS AND TYPE OF CANCER.	

2. DO YOU HAVE OR HAVE YOU HAD RECENTLY			YES	NO
WEIGHT LOSS, HOW MUCH () LBS.				
WEIGHT GAIN, HOW MUCH () LBS.				
MEMORY DEFECT				
CHANGE IN HANDWRITING				
DIFFICULTY IN WALKING IN THE DARK				
BALANCE PROBLEMS				
NUMBNESS OR TINGLING EXTREMITIES				
HEARING LOSS				
RINGING IN EARS				
VISION CHANGE				
DOUBLE VISION				
EARACHES				
RUNNING EARS				
NEW SKIN GROWTHS				
CHANGE IN SKIN COLOR				
TENDENCY TO BLEED OR BRUISE EASILY				
ATHLETES FOOT				
YELLOW JAUNDICE				
HEAT INTOLERANCE				
COLD INTOLERANCE				
CHANGE IN SHOE SIZE OR HAT SIZE				
LYMPH NODE ENLARGEMENT				
TUBERCULOSIS EXPOSURE				
KIDNEY STONES				
EXCESS USE OF ALCOHOL				
USE OF TOBACCO -- PAST OR PRESENT # _____ PACKS _____ YEARS				
EXPOSURE TO TOXIC METALS				
EXPOSURE TO ASBESTOS				
EXPOSURE TO VINYL CHLORIDE				
X-RAY TREATMENTS TO NECK, THYROID, OR TONSILS				

4. EMPLOYMENT HISTORY - PAST & PRESENT

5. HAVE YOU BEEN HOSPITALIZED OR TREATED THIS YEAR FOR WHAT YOU WOULD CONSIDER A SIGNIFICANT CONDITION? IF YES, PLEASE LIST.

DO YOU HAVE OTHER ITEMS OF PHYSICAL FITNESS YOU WANT TO BRING TO THE ATTENTION OF THE MEDICAL EXAMINER?

[] YES, IF YES, WHAT?

[] NO.

6. ARE THERE OTHER FACTORS IN YOUR PHYSICAL CONDITION NOT ALREADY COVERED THAT YOU HAVE QUESTIONS ABOUT?

WHAT?