Onslow
RADIATION ONCOLOGY

Dr. Darrel L Ross, MD, DABR
317 Western Boulevard
Jacksonville, North Carolina 28546
Phone: 910.577.4900
Fax: 910.577.4910
www.onslowradiationoncology.org

Name: <Full Name>	Pt ID: <Patient Id 1>	DOB: <Date of Birth> Age: <Age>	Today's Date: <Current Date>
Referring Physician: <Primary Referring Physician-Name Only (Default)>	Physicians: <Referring Physicians-Name Only (Default)>		
Pharmacy:	Phone: <Telephone Number>		
Reason for Visit: Consult	Patient email:		

Denotes Problem Summary Log- will be updated with each visit as needed

*Patient Medical History		
Have you been told you have	(check below)	
High Blood Pressure	☐ YES	☐ NO
Heart Trouble	☐ YES	☐ NO
Emphysema / COPD	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Diabetes Type:	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Cholesterol problems	☐ YES	☐ NO
Weight Loss (how much)_____?	☐ YES	☐ NO
Cancer Type:	☐ YES	☐ NO
Other: (list)		

*Past Surgical History			
List all operations (include minor surgeries, examples biopsies, hemorrhoids, cyst.ect.			
Operation	Date	Surgeon	City/state

Patient Medical History continued (circle symptoms you are currently experiencing)		
Constitutional	☐ Normal	Lack of appetite/ fatigue/ fever/ tired/ night sweats/rigors or chills/ change in weight
Allergic/ Immunologic	☐ Normal	Allergies/ Adverse reactions
Head	☐ Normal	Alopecia
Eyes	☐ Normal	Blurred vision/ double vision/ night blindness/ light sensitivity/ glasses
ENMT	☐ Normal	Sort throat/ difficulty swallowing/ ear pain/ nose bleed/ problems w hearing/ mouth dryness/ oral bleeding/ ear pain/ sinusitis/ sputum production/ altered taste
Neck	☐ Normal	Neck masses/ muscle weakness/ neck pain/ decreased range of motion/ swelling of neck
Integumentary	☐ Normal	Blistering/ Bruising/ dry skin/ facial burning/ nail changes/ light sensitivity/ pruritus/ rash/ hives
Breasts	☐ Normal	Breast masses/ nipple discharge/ nipple inversion/ pain
Cardiovascular	☐ Normal	Irregular heart beat/ chest pain/ swelling/ difficulty breathing when lying down/ palpitations
Respiratory	☐ Normal	Cough/ difficulty breathing/ coughing up blood/ hiccoughs/ pleuritic chest pain/ wheezing
Gastrointestinal	☐ Normal	Abdominal pain/ change in bowel habits/ constipation/ diarrhea/ heartburn/ blood in vomit/ passing blood from rectum/ hemorrhoids/ bloody, dark sticky stool, nausea/ pain, cramping/ vomiting
Genitourinary (F)	☐ Normal	Painful urination/ frequency/ genital masses/ blood in urine/ incontinence/ urinating at night/ renal stone disease/ problem with sexual function/ urgency/ urine color change/ vaginal discharge, bleeding/ spotting
Genitourinary (M)	☐ Normal	Painful urination/ frequency/ genital masses/ blood in urine/ impotence/ incontinence/ urinating at night/ renal stone disease/ retrograde ejaculation/ scrotal swelling/ urgency/ urine color change
Musculoskeletal	☐ Normal	Arthritis/ bone pain/ joint pain/ muscle swelling/ decreased range of motion
Neurologic	☐ Normal	Disorientation/ Dizziness/ abnormal gait/ headaches/ insomnia/ memory loss/ motor weakness/ sensory problems/ paralysis/seizure/ stroke
Psychiatric	☐ Normal	Delusions/ hallucinations/ mood swings/ depression/ euphoria
Endocrine	☐ Normal	Diabetes/ hot flashes/ menstrual irregularities/ thyroid disease
Hematologic/ Lymphatic	☐ Normal	Easy bruising/ tender or enlarges lymph nodes

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Allergies *Updated with each visit as needed		
Aspirin	☐ YES	☐ NO
Penicillin	☐ YES	☐ NO
Sulfur Prep.	☐ YES	☐ NO
Codeine	☐ YES	☐ NO
Latex	☐ YES	☐ NO
IV contrast	☐ YES	☐ NO
Tape	☐ YES	☐ NO
Sea Food	☐ YES	☐ NO
Eggs	☐ YES	☐ NO
Other: (list)		

Any Prior Cancer Treatments			
Radiation Therapy		☐ YES	☐ NO
TX Site & Date:	1.		
	2.		
	3.		
Chemotherapy		☐ YES	☐ NO
Drug & Date	1.		
	2.		
	3.		

Medications *Updated with each visit as needed		
Name	Amount	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9.		
10.		
11.		
12.		

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Family Medical History					
Mother	☐Alive	☐ Dead	Year of death	Age___	Health Problems?
Father	☐Alive	☐ Dead	Year of death	Age___	Health Problems?
Brother(s)	☐Alive	☐ Dead	Year of death	Age___	Health Problems?
Sisters(s)	☐Alive	☐ Dead	Year of death	Age___	Health Problems?
Children/ Male or Female	☐Alive	☐Dead	Year of death	Age___	Health Problems?
Children/ Male or Female	☐Alive	☐Dead	Year of death	Age___	Health Problems?
Children/ Male or Female	☐Alive	☐Dead	Year of death	Age___	Health Problems?
Children/ Male or Female	☐Alive	☐Dead	Year of death	Age___	Health Problems?
Family History of cancer?		☐ Yes ☐no	If yes which family member and what type of cancer?		

Social History					
Marital status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Occupation			If retired prior occupation		
Use of alcohol	☐ Never	☐Some how many a week _____ (example 3-4 beer ,wine liquor).			
Smoke tobacco	☐ Never	☐ Currently __ packs a day for ___ years		☐ Previously quit __ packs a day for ___ years	
Smokeless tobacco	☐ Never	☐ Currently __ packs a day for ___ years		☐ Previously quit __ packs a day for ___ years	
Use of drugs	☐ Never	☐ Currently what drug? _____ How many years? _____		☐ Previously, but quit what drug? _____ How many years? _____	

Pacemacker/defibrilator
Do you have a PaceMaker/Defibrilator? ☐ YES ☐ NO
If yes: please present your card to the front desk staff **What is the name of the company of your device? _____** **When was it last checked? _____** **When will it be checked next? _____**

Gynecological History (women only)							
Age at first menstrual?		# Of miscarriages?		Did you breast feed?	☐ Yes ☐no	Hormone replacement therapy ☐ Yes ☐ No for how long? _____	
# Of pregnancies?		Your age with first child?		Have you ever taken hormones?	☐ Yes ☐no		
# Of children?		Age of menopause?		Did you take Birth Control ? ☐Yes ☐ no for how long?			
Last PAP Smear	Date:	Last Mammogram	Date:	Misc:	LMP:		

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation or written authorization by the patient