



RADIATION ONCOLOGY
 VIDANT HEALTH
 CANCER PARTNER
 DR. RANDY BLACKBURN, DO/MBA
 BOARD CERTIFIED RADIATION ONCOLOGIST

317 Western Boulevard
 Jacksonville, North Carolina 28546

phone 910.577.4900

fax 910.577.4910

www.onslow.org
www.coastalconcology.com

Name:	Pt I.D. #	Current Age:	Today's Date:
Referring Physician:		Primary Physician:	
Pharmacy:	Location:	Phone:	
Chief Complaint (Why are you here)?			Your email:

Patient Medical History			Past Surgical History			
Have you been told you have (check below)			List all operations (include minor surgeries, examples biopsies, hemorrhoids, cyst.ect.			
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Operation	Date	Surgeon	City/state
Heart Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Emphysema / COPD	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Diabetes Type:	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Cholesterol problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Weight Loss (how much) _____?	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Cancer Type:	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Other: (list)						

Patient Medical History continued		
Constitutional	<input type="checkbox"/> Normal	Weight loss / Loss of appetite / Fatigue
Skin	<input type="checkbox"/> Normal	Rash / Bumps / Itching
HEENT	<input type="checkbox"/> Normal	Visual changes / Glasses / Contacts / Jaw pain / Hearing
Respiratory	<input type="checkbox"/> Normal	Shortness of breath / Wheezing / Cough / Blood in sputum
Cardiovascular	<input type="checkbox"/> Normal	Breathing pain / Chest pain / Murmur / Skipped beats / Swelling / Prop up to sleep / Cramping with exercise
Genitourinary	<input type="checkbox"/> Normal	Pain with urination / Frequent urination / Hesitancy
Gastrointestinal	<input type="checkbox"/> Normal	Nausea / Vomiting / Abdominal pain / Constipation / Diarrhea / Blood in stool / Cramping / Bloating / Heartburn
Musculoskeletal	<input type="checkbox"/> Normal	Aching / Stiffness / Joint pain / Difficulty walking
Neurologic	<input type="checkbox"/> Normal	Head ache / Numbness / Burning / Seizure
Hematologic	<input type="checkbox"/> Normal	Anemia / Easy bleeding / Bruising / Swollen glands
Immunological/allergic	<input type="checkbox"/> Normal	Allergy / Hives / Rash / Swollen glands / Night sweats
Endocrine	<input type="checkbox"/> Normal	High/low sugars / Flushing / Heat or cold intolerance
Breast	<input type="checkbox"/> Normal	Pain / Mass / Drainage / Skin change

Allergies (are you allergic to)			Medications			Any Prior Cancer Treatments		
Aspirin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Name	Amount	How Often	Radiation Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	1.			TX Site & Date:	1.	
Sulfur Prep.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	2.				2.	
Codeine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	3.				3.	
Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO	4.			Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IV contrast	<input type="checkbox"/> YES	<input type="checkbox"/> NO	5.			Drug & Date	1.	
Tape	<input type="checkbox"/> YES	<input type="checkbox"/> NO	6.				2.	
Sea Food	<input type="checkbox"/> YES	<input type="checkbox"/> NO	7.				3.	
Eggs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	8.			Immunizations		
Other: (list)			9.			Influenza Vaccine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			10.			Pneumo Vax	<input type="checkbox"/> YES	<input type="checkbox"/> NO



RADIATION ONCOLOGY
 VIDANT HEALTH
 CANCER PARTNER
 DR. RANDY BLACKBURN, DO/MBA
 BOARD CERTIFIED RADIATION ONCOLOGIST

317 Western Boulevard
 Jacksonville, North Carolina 28546

phone 910.577.4900

fax 910.577.4910

www.onslow.org
www.coastalconcology.com

Name:	Pt I.D. #	Current Age:	Today's Date:
-------	-----------	--------------	---------------

Family Medical History					
Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Dead	Year of death	Age__	Health Problems?
Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Dead	Year of death	Age__	Health Problems?
Brother(s)	<input type="checkbox"/> Alive	<input type="checkbox"/> Dead	Year of death	Age__	Health Problems?
Sisters(s)	<input type="checkbox"/> Alive	<input type="checkbox"/> Dead	Year of death	Age__	Health Problems?
Family History of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> no		If yes which family member and what type of cancer?		

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

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

Follow information to be complete by nursing staff

Pain Scale 0-10 numeric pain distress scale										
0	1	2	3	4	5	6	7	8	9	10

Physical Examination						
B/P #1 / time__:	Pulse	Resp	Temp	Height __' __" or __cm's		
B/P #1 / time__:	Weight ___lbs / ___Kg	BMI	Fatigue 0 1 2 3 4 5	KPS:		