317 Western Blvd
Jacksonville, NC 28546
Phone: (910) 577-4900
Fax: (910) 577-4910
onslowradiationoncology.org

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, including minor surgeries (biopsies, hemorrhoids, cyst, ect.)			
High blood pressure	☐ Yes	☐ No	Operation	Date	Surgeon	City/ State
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? lbs	☐ Yes	☐ No				
Cancer Type:	☐ Yes	☐ No				
Other: (list)						

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

Allergies (are you allergic to)			Medications			Medications		
Aspirin	☐ Yes	☐ No	Name	Amount	How often	Name	Amount	How often
Penicillin	☐ Yes	☐ No	1.			11.		
Sulfur prep.	☐ Yes	☐ No	2.			12.		
Codeine	☐ Yes	☐ No	3.			13.		
Latex	☐ Yes	☐ No	4.			14.		
IV contrast	☐ Yes	☐ No	5.			15.		
Tape	☐ Yes	☐ No	6.			16.		
Sea food	☐ Yes	☐ No	7.			17.		
Eggs	☐ Yes	☐ No	8.			18.		
Other: (list)			9.			19.		
			10.			20.		

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Prior Cancer Treatments								Immunizations		
Radiation therapy		☐ Yes	☐ No	Chemotherapy		☐ Yes	☐ No	Influenza vaccine	☐ Yes	☐ No
TX Site & Date	1.			Drug & Date	1.			Pneumo vax	☐ Yes	☐ No
	2.				2.					
	3.				3.					

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?
Sister(s)	☐ 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 per week			(example 3-4 beers, wine, liquor)		
Smoke tobacco	☐ Never	☐ Currently	packs a day for	years	☐ Previously, but quit	packs a day for		years
Smokeless tobacco	☐ Never	☐ Currently	packs a day for	years	☐ Previously, but quit	packs a day for		years
E-Cigarette/ Vape	☐ Never	☐ Currently	times per day for	years	☐ Previously, but quit	times per day for		years
Use of drugs	☐ Never	☐ Currently	What drug? How many years?		☐ Previously, but quit	What drug? How many years?		

Gynecological History (women only)							
Age at first menstruation?		Number of miscarriages?		Did you breast feed?	☐ Yes	☐ No	Hormone replacem ent therapy ☐ Yes ☐ No How long?
Number of pregnancies?		Your age with first child?		Have you ever take hormones?	☐ Yes	☐ No	
Number of children?		Age of menopause?		Did you take birth control?	☐ Yes	☐ No	For how long?
Last PAP Smear	Date:	Last mammogram	Date:	Misc.			