PATIENT NAME:

*Please circle **Yes** or **No** for each condition listed*

General

Fatigue	Y	N
Low Energy Level	Y	N
Fever	Y	N
Chills	Y	N
Pain, location: _____	Y	N
Weight Gain, amount: _____	Y	N
Weight Loss, amount: _____	Y	N
Loss of Appetite	Y	N

Eyes

Double Vision	Y	N
Excessive Tearing	Y	N
Impaired Vision	Y	N
Redness	Y	N
Light Sensitivity	Y	N

Skin

Nodules	Y	N
Rash	Y	N
Dry Skin	Y	N
Radiation Therapy Effect	Y	N
Nail Changes	Y	N

Breast

Breast Mass	Y	N
Breast Pain	Y	N
Nipple Discharge	Y	N

Neurologic

Abnormal Gait	Y	N
Confusion	Y	N
Dizziness	Y	N
Headache	Y	N
Memory Loss	Y	N
Numbness & Tingling	Y	N
Paralysis	Y	N
Seizures	Y	N

Difficulty breathing while lying down	Y	N
Fainting or lightheadedness	Y	N
Chest Pain	Y	N
Heart Racing	Y	N
Swelling (legs or feet)	Y	N

Respiratory

Cough	Y	N
Coughing up Blood	Y	N
Shortness of Breath	Y	N
Cough with Sputum	Y	N
Wheezing	Y	N
Pain with Breathing	Y	N

Ear/Nose/Throat

Earache	Y	N
Nose Bleeds	Y	N
Hoarseness	Y	N
Sore Throat	Y	N
Difficulty Swallowing	Y	N
Mouth Sores	Y	N
Dry Mouth	Y	N
Altered Taste	Y	N
Balance Issues	Y	N
Loss of Hearing	Y	N
Ringing in Ears	Y	N
Congestion	Y	N
Bleeding Gums	Y	N

Gastroenterology

Abdominal Cramping	Y	N
Changes in Bowel Habits	Y	N
Constipation	Y	N
Diarrhea	Y	N
Dark/Black Stools	Y	N
Nausea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Jaundice	Y	N

PLEASE TURN OVER AND COMPLETE BACK OF FORM

*Please circle **Yes** or **No** for each condition listed*

Hematology

Prolonged Bleeding	Y	N
Painful Lymph Nodes	Y	N
Easy Bruising	Y	N
Swollen Glands	Y	N

Psychiatric

Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N
Poor Concentration	Y	N
Mood Swings	Y	N

Endocrine

Cold Intolerance	Y	N
Heat Intolerance	Y	N
Increased Sweating	Y	N
Excessive Thirst	Y	N

Gynecologic

Abnormal Menstrual Periods	Y	N
Abnormal Vaginal Bleeding	Y	N
Vaginal Discharge	Y	N
Pelvic Pain	Y	N
Sexual Dysfunction	Y	N
Vaginal Dryness	Y	N

Joint Pain	Y	N
Joint Stiffness	Y	N
Back Pain	Y	N
Bone Pain	Y	N
Muscle Pain/Weakness	Y	N

Genitourinary

Burning on Urination	Y	N
Blood in Urine	Y	N
Increased Urination	Y	N
Urinary Hesitancy	Y	N

Allergy/Immunology

Eczema	Y	N
Frequent Infections	Y	N
Respiratory Infections	Y	N
Seasonal Allergies	Y	N

Patient's Signature:_____ Date: _____

Physician's Signature:_____ Date: _____

CARTI

Past Medical History Form

Office Use
B/P_____
P_____
R_____
T_____
O2_____
WT_____
HT_____

NAME:_____

AGE: _____

If negative or doesn't apply, please write **none** or **NA**.

PAST MEDICAL HISTORY (Any condition that requires medication or is followed by another physician)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ **High Blood Pressure:** **Yes** or **No**

RADIATION SAFETY ISSUES: (Please circle YES or NO for each question listed)

- **Do you have a history of an AUTOIMMUNE OR CONNECTIVE TISSUE DISORDER such as LUPUSOR SCLERODERMA?** **YES** or **NO**
  (If yes, please notify your doctor as this might affect the risk of long-term risk side effects from radiation.)
- **Do you have a PACEMAKER or DEFIBRILLATOR?** **YES** or **NO**
  (If yes, we will need a copy of your device card for radiation safety purposes)
- **FEMALES: IS THERE A CHANCE YOU ARE PREGNANT?** **YES** or **NO**

PAST SURGICAL HISTORY: (2 – 3 most recent surgeries or those pertinent to your cancer)

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

PRIOR RADIATION TREATMENT: (If YES, include When / Where) _____

PRIOR CHEMOTHERAPY: (If YES, include When / Where) _____

MEDICATIONS: (or PROVIDE CURRENT LIST)

DRUG NAME	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PLEASE TURN OVER AND COMPLETE BACK OF FORM

PHARMACY:_____ **LOCATION:** _____

DRUG ALLERGIES: (Please provide allergic symptoms— Rash, itching, etc.)

1. _____ **Reaction:** _____

2. _____ **Reaction:** _____

3. _____ **Reaction:** _____

Latex Allergy? **YES** or **NO** **Reaction:** _____

Iodine Allergy? **YES** or **NO** **Reaction:** _____

FAMILY "CANCER" HISTORY: (Please indicate type of cancer)

Father:

Mother:

Siblings and / or Children:

Other family members:

SMOKING HISTORY: (check appropriate box)

Have you ever smoked cigarettes? ☐ Never smoked ☐ Previous smoker ☐ Current smoker

If you did or now smoke cigarettes, how many packs per day?_____ Age started _____

If you quit smoking, when did you quit? _____

Do you use any other tobacco products? _____

ALCOHOL USE: How much?_____ How often?_____

HAZARDOUS OCCUPATIONAL EXPOSURE:

GYNECOLOGIC/OBSTETRIC HISTORY: (women only)

Number of pregnancies: _____

Number of live births: _____

If premenopausal, date of last period: _____

If postmenopausal, age of menopause: _____

Did you take hormone replacement therapy after menopause? **YES** or **NO** (circle one)

If yes, for how many years? _____

_____

Signature Date \ Time