CARTI

PAST MEDICAL HISTORY

NAME: _____

AGE: _____

Office Use			
B/P:	_____	O2:	_____
P:	_____	WT:	_____
R:	_____	HT:	_____
T:	_____	MRN:	_____

If negative or doesn't apply, please write **none** or **N/A**.

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 ☐ No

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

Do you have a history of an AUTOIMMUNE or CONNECTIVE TISSUE DISORDER such as LUPUS or SCLERODERMA? ☐ Yes ☐ No
(If yes, please notify your doctor as this might affect the risk of long-term side effects from radiation.)

Do you have a PACEMAKER or DEFIBRILLATOR? ☐ Yes ☐ No
(If yes, we will need a copy of your device card for radiation safety purposes.)

Do you have any other IMPLANTED ELECTRONIC DEVICES? ☐ Yes ☐ No

FEMALES: IS THERE A CHANCE YOU ARE PREGNANT? ☐ Yes ☐ No

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

1. _____
2. _____
3. _____

PRIOR RADIATION TREATMENT: ☐ Yes ☐ No (If YES, please include When/Where) _____

PRIOR CHEMOTHERAPY: ☐ Yes ☐ No (If YES, please include When/Where) _____

MEDICATIONS: (or provide current list)

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

PHARMACY: _____ **LOCATION:** _____

CARTI

PAST MEDICAL HISTORY

DRUG ALLERGIES: (Please provide allergic symptoms – rash, itching, etc.)

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Latex Allergy? ☐ Yes ☐ No Reaction: _____

Iodine Allergy? ☐ Yes ☐ 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? ☐ Yes ☐ No What kind? _____

ALCOHOL USE: How much? _____ How often? _____

HAZARDOUS OCCUPATIONAL EXPOSURE: ☐ Yes ☐ No (If yes, please explain.)

_____

_____

_____

GYNECOLOGIC/OBSTETRIC HISTORY: (Women Only)

Number of Pregnancies: _____ Number of live births: _____

Have you ever used contraceptive hormones (birth control)? ☐ Yes ☐ No

If yes, for how many years? _____

If premenopausal, date of last period: _____

If postmenopausal, age of menopause: _____

Did you take hormone replacement therapy after menopause? ☐ Yes ☐ No

If yes, for how many years? _____

When was your last Pap smear? _____ When was your last mammogram? _____

Patient's Signature: _____ Date: _____

CARTI

REVIEW OF SYSTEMS FORM

Patient Name: _____

Please check 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	☐
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

Cardiac

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

CARTI

REVIEW OF SYSTEMS FORM

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

Musculoskeletal

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: _____