



**RADIATION ONCOLOGY
PATIENT QUESTIONNAIRE**

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

ACCOUNT NUMBER: _____

DATE OF SERVICE: _____

Check Symptoms You Currently Have

General/Skin	Neurologic	Genitourinary
☐ Fever or Chills	☐ Headache	☐ Frequent Urination
☐ Night sweats	☐ Dizziness	☐ Painful Urination
☐ Weight loss	☐ Numbness	☐ Blood in Urine
☐ General Fatigue	☐ Weakness	☐ Incontinence
☐ Rash	Mood	☐ Libido/Potency
Head & Neck	☐ Anxiety	☐ Vaginal Bleeding
☐ Vision Change	☐ Depressed Mood	Digestive Tract
☐ Hearing Loss	☐ Sleep Changes	☐ No appetite
☐ Sore Throat	☐ Lack of enjoyment	☐ Trouble swallowing
☐ Hoarse Voice	Heart & Lung	☐ Nausea
☐ Swollen Glands	☐ Cough	☐ Vomiting
Blood System	☐ Short of Breath	☐ Heartburn/GERD
☐ Easy Bleeding	☐ Chest Pain/Palpitations	☐ Abdominal Pain
☐ Easy Bruising	☐ Smoking History- If yes,	☐ Bloody/Black Stools
☐ Swollen Glands	# of years____Packs/day____	☐ Diarrhea
Joints	If you quit, what year_____	☐ Constipation
☐ Joint Swelling		☐ Jaundice (Yellow)
☐ Joint Pain		
☐ Joint Stiffness		

Personal History

Age_____ What is/was your occupation: _____

Marital Status (circle one) Single Married Widowed Divorced Domestic Partner

Do you have any children ☐ No ☐ Yes, If yes, how many? _____ Grandchildren? _____

What hobbies/special interests do you have? _____

Do you have a previous history of cancer? If yes, please describe: _____

Have you ever received radiation therapy before? ☐ No ☐ Yes, if yes, where and when? _____

Family History

Do you have any blood relatives who have ever had cancer? ☐ No ☐ Yes, If yes describe their relationship to you and the type of cancer _____

Coping/Stress

In the past year, have there been any major events? ☐ No ☐ Yes, if yes, what? _____

Who or what is most helpful when you are under stress? _____

What is your main concern regarding your illness and treatment? _____

What else would you like us to know about you? _____

Patient Signature _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____



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