CAMPBELL COUNTY HEALTH
501 SOUTH BURMA AVENUE
GILLETTE, WYOMING 82716
P-307-688-1950
F-307-688-1974

HEALTH QUESTIONNAIRE
RADIATION ONCOLOGY

RH NURSES

Name: ______________________ Age: __________ Date: ____________________

Diagnosis: ____________________________ Accompanied by: ____________________

Phone Number: ____________ Cell Phone: ______________ Work Number: ________________

Please write a brief description of the medical problem resulting in your referral to this department:

____

FOR CLINIC USE ONLY

Height: ________ **Weight:** ________**LB** ________ **KG**

Blood Pressure: _______ **Pulse:** _______ **Resp:** ________ **O2 Sat:** ________ **Temp:** _______

Pain: Scale (0-10) ________ **Site** ________ **Description:** ______________________

Primary Doctors, Surgeons and Cancer Doctor: ______________________________________

____

____

Previous Treatment: Radiation Yes _______ No _______
Chemotherapy Yes _______ No _______
Surgery Yes _______ No _______
Hormone Therapy Yes _______ No _______
Allergies: Medications / Medical Supplies Yes _______ No _______ If **YES**, list: ________________
Seasonal Allergies Yes _______ No _______

Please list your current medications / vitamins / supplements:

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

7. ______________ 8. ______________ 9. ______________

Family history of cancer: Yes _______ No _______ If **YES**, please state whom and what type:

____

Please list all major surgeries: ____

____

Marital Status: Single______ Married ______ Widowed ______ Divorced ______

Occupation: ____________________________ **Retired:** Yes _______ No _______

Highest level of education: ______________________

Pharmacy Preference: ____

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Please indicate whether you have experienced any of the following problems or conditions in the past 12 months:

GENERAL			CARDIOVASCULAR		
Fever, Chills, Sweats	YES	NO	Bleeding Problems	YES	NO
Body Piercing / Tattoos	YES	NO	Blood Clots	YES	NO
General Weakness	YES	NO	Irregular Heartbeat	YES	NO
Cold most of the time	YES	NO	Palpitations	YES	NO
Thirsty all of the time	YES	NO	High Blood Pressure	YES	NO
Unusually Tired / Sluggish	YES	NO	Rheumatic Fever	YES	NO
Unusually Nervous / Jumpy	YES	NO	Heart Valve Problem or Murmur	YES	NO
Weight Loss, If yes how much?	YES	NO	Arm or Leg Pain / Cramps	YES	NO
Unexplained Fatigue	YES	NO	Arm or Leg Swelling	YES	NO
Palpable Lumps or Bumps	YES	NO	Heart Attack	YES	NO
Sores that won't heal	YES	NO	Congestive Heart Failure	YES	NO
HEENT			**GASTROINTESTINAL**		
Blurred or double vision	YES	NO	Poor Appetite	YES	NO
Light Flashes	YES	NO	GF Reflux Disease	YES	NO
Pain in Eyes	YES	NO	Indigestion or Heartburn	YES	NO
Glaucoma	YES	NO	Stomach Ulcer	YES	NO
Ear Pain	YES	NO	Nausea or Vomiting	YES	NO
Drainage from Ears	YES	NO	Diarrhea or Constipation	YES	NO
Hearing Loss	YES	NO			
Buzzing or Ringing in Ears	YES	NO	Abdominal Pain / Cramps	YES	NO
Nosebleeds	YES	NO	Blood in Stool or Black Stool	YES	NO
Sinus Problems	YES	NO	Change in Bowel Habits	YES	NO
Problem Swallowing	YES	NO	Pain with Bowel Movements	YES	NO
Sore Throat or Mouth	YES	NO	Abdominal Swelling	YES	NO
Persistent Hoarseness	YES	NO	Uncontrolled Loss of Stool	YES	NO
Difficulty Opening Mouth	YES	NO	High Cholesterol	YES	NO
Neck Pain or Swelling	YES	NO	Hepatitis or Liver Disease	YES	NO
Headaches	YES	NO	Yellow Skin or Eyes	YES	NO
RESPIRATORY			**PSYCH / NEURO**		
Coughing up Blood	YES	NO	Weakness	YES	NO
Frequent Cough	YES	NO	Clumsiness	YES	NO
Night Sweats	YES	NO	Tingling or Numbness	YES	NO
Shortness of Breath	YES	NO	Dizziness or Vertigo	YES	NO
Wheezing	YES	NO	Fainting Spells	YES	NO
Asthma	YES	NO	Trouble with Balance	YES	NO
COPD or Emphysema	YES	NO	Shooting Pains	YES	NO
Tuberculosis	YES	NO	Unusual Behavior Changes	YES	NO
Sleep Apnea	YES	NO	Memory or Intellectual Changes	YES	NO
Oxygen Use	YES	NO	Unusual Emotional Changes	YES	NO
Chest Pain	YES	NO	Seizures	YES	NO
Bronchitis or Pneumonia	YES	NO	Depression	YES	NO
			Mental Illness	YES	NO

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MUSCULOSKELETAL

Painful / Swollen Joints	**YES**	**NO**
Lumps / Swelling Muscles	**YES**	**NO**
Pain in Bones	**YES**	**NO**
Back Problems	**YES**	**NO**
Osteoporosis	**YES**	**NO**
Muscle Disorder (Myasthenia Gravis, etc)	**YES**	**NO**
Rheumatoid Arthritis	**YES**	**NO**

GU

Painful / Burning Urination	**YES**	**NO**
Frequent Urination	**YES**	**NO**
Uncontrolled Loss of Urine	**YES**	**NO**
Little warning prior to urination	**YES**	**NO**
Trouble Starting Stream	**YES**	**NO**
Blood in Urine	**YES**	**NO**
Kidney Stones	**YES**	**NO**

MALE GU

Sore or Discharge from Penis	**YES**	**NO**
Pain or Blood with Ejaculation	**YES**	**NO**
Lump in Testicle	**YES**	**NO**
Difficulty achieving an erection	**YES**	**NO**

HABITS

Smoke Cigars / Cigarettes	**YES**	**NO**
How much ______________________		
Drink Alcohol	**YES**	**NO**

ENDOCRINE

Diabetes	**YES**	**NO**
Hypoglycemia	**YES**	**NO**
Thyroid Problems	**YES**	**NO**

HEMATOLOGICAL

Cancer or Leukemia	**YES**	**NO**
Ever Received Blood	**YES**	**NO**

GYN

Breast Lump	**YES**	**NO**
Pain in Breast	**YES**	**NO**
Nipple changes or discharge	**YES**	**NO**
Vaginal Discharge	**YES**	**NO**
Pain with sexual intercourse	**YES**	**NO**
Vaginal Bleeding or Spotting	**YES**	**NO**
between Menses	**YES**	**NO**
Pelvic Pain	**YES**	**NO**
Last period Date	**YES**	**NO**
Pregnancies # ______	**YES**	**NO**
Miscarriages # ______	**YES**	**NO**
Live Births # _______	**YES**	**NO**
Ever Taken Hormones	**YES**	**NO**

FAMILY HISTORY

Has any Blood Relative had the following:

Sickle Cell Disease	**YES**	**NO**
Collagen Disease (Lupus, Scleroderma, etc)	**YES**	**NO**
Anemia	**YES**	**NO**
Cancer or Leukemia	**YES**	**NO**
Bad Reaction to Anesthesia	**YES**	**NO**
Rheumatoid Arthritis	**YES**	**NO**