CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

Patient Name:		**Birth date:** **Height:**		**Race:**
Address:		**City/State/Zip:**		☐**Male** ☐**Female**
Marital Status:	**# Of Children:**	**Home Phone:**	**Cell Phone:**	
Primary Caregiver:		**Do you have a living will?** □**Yes** □**No** (If yes, please provide a copy.) **Do you have a Durable Power of Attorney?** □**Yes** □**No** (If yes, please provide a copy.)		

Are you a citizen of a European Union member country? ☐**Yes** ☐**No**

INSURANCE INFORMATION:

Primary: _____ Member ID:_____ Group: _____

Secondary:_____ Member ID:_____ Group:_____

Spouse Name:_____Spouse DOB:_____

Spouse Employer:_____ Phone:_____

Referring Physician :_____

Additional Physicians: _____

Reason for your visit today:

Do you have a PORT/VASCULAR DEVICE? ☐**Yes** ☐**No**

Do you have an Implanted Pacemaker or Defibrillator? ☐ **Yes** ☐**No** (If yes, please show the Nurse your card.)

Have you received radiation in the past? ☐**Yes** ☐**No** **Area:** **Year:** **Where:**

Have you or are you currently receiving Chemotherapy? ☐**Yes** ☐ **No** **Year:** **Chemo Doctor:**

Problems/Illnesses (Circle all that apply to you.)

AIDS/HIV **Alzheimer's/Dementia** **Arthritis** **Asthma** **Cardiac Disease/Heart Problems**
Diabetes **Emphysema or COPD** **GERD (reflux/heartburn)** **Hepatitis** **High Cholesterol**
High Blood Pressure **Hypothyroid (low) or Hyperthyroid (high)** **Kidney Disease/Dialysis** **Stroke or TIA's**
Other (please describe): _____

(Female only) Date of last mammogram: **Date of last Pap smear:**

Last Menstrual Period: **Menopause:** ☐ **Yes** ☐**No**

SURGERIES (Provide approximate dates): **Colonoscopy:** ☐ **Yes** ☐**No** **Date:**

Drug Allergies - Medication	**Reaction**

Have you ever received intravenous contrast? ☐ **Yes** ☐**No** **Any reaction to contrast?** ☐**Yes** ☐**No**

Do you have any seafood allergies? ☐**Yes** ☐**No**

PREFERRED PHARMACY: **LOCATION:** **PHONE:**

MEDICATION HISTORY: List Medications Below or Attach List			
Name of Medication	**Strength**	**Frequency**	**Reason for taking**

FAMILY HISTORY

Father □ Living □ Deceased Age_____ | **Mother** □ Living □ Deceased Age_____

Check all that apply:	Father	Mother	Brother	Sister
Hypertension	□	□	□	□
Heart Disease/Attack	□	□	□	□
Stroke	□	□	□	□
Diabetes	□	□	□	□
Cancer (describe below)	□	□	□	□
Other (describe below)	□	□	□	□

SOCIAL HISTORY

Tobacco use at present? □Yes □No **Type:**□Cigarettes □Cigars □Pipe □Oral Tobacco **Daily Amount:** **Years:**

Tobacco use in the past? □Yes □No **When did you quit?**

Do you drink alcoholic beverages? □Yes □No **Type of alcohol:** **How much and how often:**

Any illegal "street" drug use: Present:□Yes □No **Type:** **Past:**□Yes □No **Type:**

Education: Highest-grade completed-_____ **Retired:** □Yes □No **Are you employed?** □Yes □No

Occupation: _____**Employer:** _____

Employer Phone:_____ **City, St.:**_____

Any exposure to chemicals or hazardous materials? □Yes □No **Type:** _____

REVIEW OF SYSTEMS (symptoms within last two weeks) (circle all that apply)

Poor Appetite	Hair Loss	Bloody Vomit	Muscle Weakness
Fatigue	Increased Skin Sensitivity to Sun	Rectal Bleeding	Range of Motion
Fever	Hives/Itching/Rash	Hemorrhoids	Describe _____
Night Sweats	Breast Masses	Black Tarry Stools	Disorientation/Confusion
Weight Change	Nipple Discharge	Nausea	Dizziness
Blurred vision	Nipple Inversion	Abdominal Pain/Cramping	Difficulty Walking
Double Vision	Breast Pain	Vomiting	Headaches
Visual Difficulties	Heart Racing	Burning in Urination	Nerve Pain/Neuropathy
Difficulty Swallowing	Chest Pain	Frequent Urination	Seizure
Impaired Hearing	Swelling to feet and legs	Blood in Urine	Anxiety
Hoarseness	Cough	Impaired Sex Function/Impotent	Hallucinations
Mouth Dryness	Shortness of Breath	Loss of Bladder/Bowel	Depression
Oral Bleeding	Coughing up Blood	Waking at Night to Urinate	Diabetes
Mouth Sores	Chest Pain upon Breathing	Urine Urgency	Hot Flashes
Neck Pain	Wheezing	Vaginal Discharge/Bleeding	Thyroid Disease
Swelling in Neck	Constipation	Bone Pain	Easy Bruising
Blisters on Skin	Diarrhea	Joint Pain	Swollen Lymph Nodes
Other: _____			

I attest that all of the information in this document is true, correct to the best of my knowledge, and understand that my physician will base his opinions and judgements on the same.

_____ _____

Patient Signature **Date**