RADIATION CENTER OF GREATER NASHUA

RADIATION CENTER OF GREATER NASHUA
CONFIDENTIAL HEALTH HISTORY

Please fill out the information on both pages of this form. This will help us serve you better. Thank You.

Name_____ Date of Birth _____Occupation_____

Reason(s) for visit today _____

Please list the names of all your doctors _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medications No ☐ Yes ☐ (please list below)

Name of medication(s) you are *allergic* to:	**Please describe your allergic reaction:**

Have you previously had Radiation Treatment? ☐ Yes ☐ No **If yes, when and where did you have Radiation Treatment?**

_____

Have you previously had Chemotherapy? ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes ☐ No How much every week? _____

Do you currently smoke? ☐ Yes ☐ No How many packs/day_____ For how many years_____

Have you ever smoked? ☐ Yes ☐ No How many packs/day_____ For how many years_____
When did you quit? _____

MEDICAL HISTORY Check (☐) the medical conditions you have now or have had in the past

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallbladder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes/shingles
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Other_____

Please check the following tests you have had in the past 6 months:

- ☐ Blood tests
- ☐ Bone scan
- ☐ CT scan
- ☐ MRI
- ☐ X-ray

Other_____

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Name:_____ **Date of Birth:**_____

Surgeries / Hospitalizations / Injuries

Year	Please explain

PRESENT SYMPTOMS: Check (☐) the symptoms you are presently having or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Pain
- ☐ Sweats

Nutritional Status
- ☐ Loss of Appetite
- ☐ Difficult swallowing
- ☐ Nausea/Vomiting
- ☐ Pain on swallowing
- ☐ Weight Loss
- ☐ Weight gain

Skin
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Skin changes
- ☐ Sore won't heal

Gastrointestinal
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Blood in stool

Urinary-Bladder
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of control
- ☐ Painful urination

Cardiovascular
- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heart Rate
- ☐ Fast/Slow Heart Rate
- ☐ Swelling: legs, arms.

Muscle/Joint/Bone
- ☐ Weakness
- ☐ Difficulty walking
- ☐ Fatigue
- ☐ Arthritis
- ☐ Pain
- ☐ Stiffness

Eyes, Ears, Nose,
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Double vision
- ☐ Earache/pain
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- flashes
- ☐ Vision –halos

Respiratory
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of Breath
- ☐ On Oxygen
- ☐ Pain on breathing

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Hot flashes
- ☐ PSA test
  Date_____

Women only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Hot flashes
- ☐ Still have period
- ☐ Am going through menopause
- ☐ Went through menopause
- ☐ Age at menses _____
  first period _____ last period _____
- ☐ Date last Pap Smear _____
- ☐ Date last Mammogram _____
- ☐ No. of children_____
- ☐ No. of pregnancies_____
- ☐ Age 1st pregnancy _____

Breastfeed ☐ Yes ☐ No

Hormone Replacement
☐ Yes ☐ No
How long? _____

Birth Control Pill
☐ Yes ☐ No
How long? _____

Family History of Cancer

Relationship to you	Type of Cancer

I certify that the above information is correct to the best of my knowledge. I agree not to hold my doctor or any members of the Radiation Center of Greater Nashua responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____**Date**_____