Alliance Radiation Oncology at Anna Jaques Hospital	**Initial Patient History Questionnaire**	**Patient Name:** **Medical Record #:** **Date of Birth:**

Date_____

Allergies: ☐ NONE ☐ Shellfish ☐ Iodine ☐ Latex ☐Penicillin
☐ Sulfa ☐ Other: _____

Primary Language: _____
Other Language: _____
Last grade completed: _____

How do you like to learn?
☐Hear/Verbal ☐Video ☐Demonstration ☐Read

Who referred you to our facility?
☐ Your Doctor ☐ Yourself ☐Radio ☐Billboard ☐Internet ☐Ad
☐ News story ☐ Friend/Family ☐Have been here before as a patient

Where did you first hear about our facility?
☐ Your Doctor ☐Radio ☐Billboard ☐Internet ☐Ad ☐ News story

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow
Occupation: _____
Who is available to help you if you need it? _____
_____
Do you smoke?
☐ **No** Did you quit? ☐Yes When? _____
How many packs did you smoke/day _____
For how many years? _____
☐ **Yes** How many packs/day? _____For how many years? _____

Do you drink alcohol? ☐ No ☐ In recovery
☐ Yes How often? _____
Do you take drugs other than those from a doctor?
☐ No ☐ Yes, _____
Do you _____live alone? _____with family? _____other?

Do you drive? ☐ No ☐ Yes
Are you receiving home care services? ☐ Nurse ☐ Therapy ☐ Hospice
How do you feel about being here today?
☐ Angry ☐Anxious ☐Concerned ☐Helpless ☐Hopeless ☐Depressed ☐Scared
☐ Positive ☐ Supported ☐Isolated
☐ Overwhelmed ☐Hopeful ☐ Relieved
☐ Other: _____
Do you have an Advanced Medical Directive/Living Will or Power of Attorney? ☐ No
☐ Yes - Please give us a copy for your chart

Would you like a referral to a social worker? ☐ No ☐ Yes
Would you like a referral to a dietitian? ☐ No ☐ Yes
Would you like a referral for spiritual needs? ☐ No ☐ Yes
Do you have any religious/cultural/spiritual beliefs we should be aware of to better care for you?
☐ No
☐ Yes, Please describe: _____
How is your appetite? ☐Good ☐Fair ☐Poor
Have you lost weight in the last 6 months? ☐ No ☐Yes
How many pounds? _____
On purpose? ☐No ☐Yes

Please indicate yes/no to the following:	Yes	No
Heart Disease (Heart attack, angina, CHF)		
Pacemaker/Defibrillator		
Stroke		
Diabetes (sugar problems)		
Hypertension (high blood pressure)		
Emphysema		
Tuberculosis		
Pneumonia		
Peptic Ulcer		
Bowel Problems		
Hepatitis		
Urinary Problems (kidney/bladder)		
History of sexual or physical trauma		
Do you feel safe in your home?		
Are you/could you be pregnant?		
Gynecologic problems (infections, etc.)		
Depression or mental illness		
Have you ever attempted suicide?		
History of substance abuse		
Thyroid problems		
Seizures		
Personal History of Cancer		
Previous Chemotherapy		
Previous Radiation Therapy (if yes, please list areas of body treated):		
List Hospital/Facility where treated:		
Please list any previous surgeries:		
Family history of cancer (if yes, please list):		

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1 Wallace Bashaw Jr. Way
Newburyport, MA 01950
Main number: 978-997-1351
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Patient signature:
_____
Date: _____

Staff Only:
Reviewed by: