

**INOVA-LOUDOUN HOSPITAL  
RADIATION ONCOLOGY CENTER  
NEW PATIENT HISTORY CHECKLIST**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

FAMILY MD: \_\_\_\_\_ TEL: \_\_\_\_\_ MED ONC: \_\_\_\_\_ TEL: \_\_\_\_\_

SURGEON: \_\_\_\_\_ TEL: \_\_\_\_\_ OTHER MD: \_\_\_\_\_ TEL: \_\_\_\_\_

**PAST AND PRESENT ILLNESSES & CURRENT SYMPTOMS: (Please check all that apply)**

PROBLEM	YES	NO	COMMENTS
Stroke/seizures/headaches			
Neck or back pain/arthritis			
Heart Disease (Heart attack, chest pain, congestive heart failure, irregular beats, pacemaker/implantable defibrillator)			
High Blood Pressure			
Diabetes			
Emphysema/asthma/pneumonia/tuberculosis/cough			
Thyroid disease			
Peptic Ulcer/acid reflux/gallbladder disease			
Bowel Problems (constipation, diarrhea, irritable bowel)			
Hepatitis/jaundice/HIV			
Urinary Problems (Kidney/Bladder/Prostate)			
Gynecologic Problems (Infections, abnormal Paps)			Date of last menstrual period:
Prior Cancer Diagnosis/RADIATION THERAPY			Area treated:
Other:			

Mental Health: circle those that apply:    depression    bipolar    schizophrenia    panic/anxiety

SURGICAL PROCEDURE	LOCATION (HOSPITAL)	DATE OF SURGERY

HABIT	YES	TYPE	AMOUNT
SMOKING		Cigar/Cigarette    Pipe    Chewing Tobacco	
ALCOHOL		Wine    Beer    Mixed Drinks    Hard Liquor	
DIET		Diabetic    Low Sodium    Low Fat    Other (Explain →)	

**DAILY MEDICATIONS: (Please list medication, dosage, how often)**

_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES: (Please list any allergies to medications, tape, latex, etc. and type of reaction.)**

_____	_____
_____	_____
_____	_____

**FAMILY HISTORY: (Please list relationship and type of cancer or illness)**

CANCER: \_\_\_\_\_

\_\_\_\_\_

OTHER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_