

RADIATION ONCOLOGY MEDICAL HISTORY FORM

Patient Name: _____ Home Phone: () _____
Preferred Name (Nickname) _____ Cell Phone: () _____
Occupation: _____ Work Phone: () _____
Alternative Local Contact Name: _____ Phone: () _____
Please list your Primary (Family) Physician: _____
Other Physicians: _____
Pharmacy: Name: _____ Location: _____ Phone Number: () _____

Medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____

Are you allergic to any medications? YES _____ NO _____ If yes, please list:

1. _____ 2. _____

Surgeries/Operations you have had:

1. _____ 2. _____
3. _____ 4. _____

Have you ever had Radiation treatments? YES _____ NO _____ If yes, when & where?

Have you ever had Chemotherapy? YES _____ NO _____ If yes, when & where?

Medical problems that you currently have:

1. _____ 2. _____
3. _____ 4. _____

Do you have Living Will? YES _____ NO _____ Do you have Advanced Directives? YES _____ NO _____

If yes to the above, we would appreciate a copy for our records.

If no to the above, would you like information regarding them? YES _____ NO _____

Patient Signature

Date