Oncology patient health assessment

Patient to complete

Patient information:

Given names:

Surname:

Date of birth:

Height (cm):

Weight (kg):

Medical history

Have you had any previous radiation treatment?

○ Yes
○ No

Please specify which department:

Doctor:

What part of your body?

Date of previous treatment: month/year

Have you had any previous chemotherapy?

○ Yes
○ No

Date of previous treatment: month/year

Doctor:

Have you had any form of cancer previously (including skin)?

○ Yes
○ No

Please specify type & treatment:

Do you have a pacemaker, internal defibrillator or any other internal device?

○ Yes
○ No

If yes, please bring your pacemaker card with you

Have you had any joint replacements?

○ Yes
○ No

Please specify:

Have you ever had a blood clot in your legs (DVT) or lungs (PE)?

○ Yes
○ No

Please specify:

Have you had any heart or lung problems?

○ Yes
○ No

Please specify:

Do you currently have any pressure injuries, ulcers, or open wounds?

○ Yes
○ No

Please specify:

Do you suffer from depression/anxiety/ mental health/claustrophobia issues?

○ Yes
○ No

Please specify:

Do you suffer from high or low blood pressure?

○ Yes
○ No

Please specify:

Do you suffer from diabetes?

○ Yes
○ No

Please specify type:

Have you ever been diagnosed with an antibiotic-resistant illness? E.g. MRSA/VRE? OR an infection that has been hard to treat?

○ Yes
○ No

Please specify:

Do you have an immune suppressive condition e.g. HIV or hepatitis?

○ Yes
○ No

Please specify:

Have you had a fall within the past 12 months?

○ Yes
○ No

Approximate date:

Injury:

Do you have an Advance Care Directive?

○ Yes
○ Copy provided
○ No

If Yes please bring the original or a certified copy with you to your doctor's appointment.

If No, would you like further information?
○ Yes ○ No

Office use only:

Patient ID number:

Physician:

GenesisCare

Patient information:

Given names:	Surname:	Date of birth:

Operations

Please list any previous operations and dates below

Family cancer history

Do you have any family history of cancer?

○ Yes
○ No

Please specify:

Social history

Do you drink alcohol?

○ Yes
○ No

How frequently:

Do you or have you ever smoked?

○ Yes
○ No

Years: Number per day:

Date stopped:

Do you exercise?

○ Yes
○ No

How frequently:

Medications

If you do not have a current printed list of your medications from your GP, please list current medications and dosage (if known) below:

Allergies/sensitivities

Product/drug/food/ other (e.g. reaction to cold):	Reaction experienced/ area affected:
Product/drug/food/ other (e.g. reaction to cold):	Reaction experienced/ area affected:

Any other medical problems?

○ Yes
○ No

Please specify:

Patient signature	Date of completion