KAISER PERMANENTE®

Radiation Oncology: Patient questionnaire

Please check the boxes below for any symptoms or conditions that apply to you. If you're not sure about how to answer, ask our receptionist, doctor, or nurse for help.

General	Bones, muscles, and joints
☐ Fever over 100 degrees F ☐ Weight loss of _______pounds in _________months ☐ Feeling very tired or fatigued ☐ Sweats	☐ Bone pain ☐ Joint pain or stiffness
Heart	**Skin**
☐ Chest pain while walking or during exercise ☐ Irregular heartbeat ☐ Fainting	☐ Lumps under the skin ☐ Rash ☐ New spots ☐ Sores that won't heal ☐ Yellowing of eyes or skin (jaundice)
Lungs	**Nervous system**
☐ Serious cough that brings up a lot of mucus or phlegm ☐ Coughing up blood ☐ Shortness of breath ☐ Chest pain	☐ Numbness ☐ Weakness in hand, arm, or leg ☐ Problems with balance
Digestion	**Brain, memory, and hearing**
☐ Loss of appetite ☐ Dry mouth ☐ Problems chewing ☐ Problems swallowing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Pain in stomach or abdomen ☐ Heartburn	☐ Problems remembering things ☐ Hard time finding the right word ☐ Hard time concentrating ☐ Double vision ☐ Blurred vision ☐ Problems hearing ☐ Serious headaches
Urinary	
☐ Frequent urination at the night ☐ Sudden need to urinate ☐ Blood in urine ☐ Leaking urine	

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Please answer the following questions

Are you having pain now? ☐ No ☐ Yes

If YES, where is your pain?_______________

How often are you in pain?_______________

When did your pain start?______________

How would you describe your pain on a scale from 0 to 10, with 0 being no pain and 10 being worst pain ever?

0 1 2 3 4 5 6 7 8 9 10

Mild Average Worst

Are you controlling your pain with medicine? ☐ No ☐ Yes

If YES, what pain medicine do you take? _________________________

How often do you take this pain medicine? ________________________

Do you live in an Assisted Living Facility, Adult Family Home, Nursing Home? ☐ No ☐ Yes

May we give information about your health to another person? ☐ No ☐ Yes

Name of person	Relationship to you
________________________________	_________________________________
________________________________	_________________________________

Does anyone from Home Health or Hospice visit you at home? ☐ No ☐ Yes

Have you been able to continue most of your normal activities? ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes-If yes, how many days per week: _________

FOR WOMEN:
Pregnant women should not receive radiation treatment.
ARE YOU or COULD YOU BE PREGNANT NOW? ☐ No ☐ Yes
If there is any chance that you might be pregnant, please tell us right away.
Radiation can be harmful to unborn babies.

Age at **first** menstrual period: _____
Date of **last** menstrual period: _____
Age at menopause: _____
Have you used estrogen? ☐ No ☐ Yes

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