

MRN:
Patient Name:
(Patient Label)

**PATIENT HEALTH QUESTIONNAIRE**  
**Radiation Oncology**

REVIEWED DATE / INITIALS									

Safety:	Yes	No
Are you at risk for falls?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Females; Is there a possibility you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Allergies:	Yes	No	If YES, please list medication allergies:
Do you have any allergies to medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you allergic to iodine/IV contrast dye?	<input type="checkbox"/>	<input type="checkbox"/>	

Prior History of Radiation Therapy
• Where in the body were you radiated?
• Approximate number of therapies?
• How many weeks? (one day, one week, 2-weeks, 3-weeks, 4-6 weeks):
• Location/Hospital/Clinic that provided radiation therapy:

Prior History of Chemotherapy
• Currently on chemo or has completed chemotherapy in the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No
○ If YES, how many cycles have you completed?
○ If YES, date of last chemo dose:
○ Please list the names of chemo drugs you received:

Cancer History								
Type	Yes	No	Type	Yes	No	Type	Yes	No
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Bone	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Small Intestine	<input type="checkbox"/>	<input type="checkbox"/>
Brain	<input type="checkbox"/>	<input type="checkbox"/>	Lung	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	Uterine	<input type="checkbox"/>	<input type="checkbox"/>
Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic	<input type="checkbox"/>	<input type="checkbox"/>	Other – Specify		
Colon	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>			

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**Medical History:**

	Yes	No		Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Nerve/Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
CHF	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical History: \_\_\_\_\_

**Surgical History:**

	Yes	No		Yes	No
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>
Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>

Other Surgical History: \_\_\_\_\_

**Do you have any of the specific medical conditions listed below:**

	Yes	No
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

**Have you ever had:**

	Yes	No
Previous Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Previous Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>

**Gynecological (female patients only):**

		Yes	No
Number of pregnancies: _____	Have you ever taken oral contraceptives or hormone replacement medication? If yes, what type:	<input type="checkbox"/>	<input type="checkbox"/>
Number of children:			
Age at first live birth:			
Age periods first started:	Date of last Pap Smear:		
Age at menopause (if postmenopausal):	Date of last Mammogram:		
Menopause Status: <input type="checkbox"/> Premenopausal <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Don't know			

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**Family History:**

	Yes	No
<b>Have any of your family members ever had cancer?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list relationship and type of cancer in your family member(s):		

**Social History:**

<b>Smoking</b>	Yes	No
Never smoked	<input type="checkbox"/>	<input type="checkbox"/>
Smoke currently	<input type="checkbox"/>	<input type="checkbox"/>
Smoked previously	<input type="checkbox"/>	<input type="checkbox"/>

<b>If you smoke currently or have smoked in the past:</b>	
Number years smoked	
Number packs per day	
Number years quit	

<b>Alcohol</b>	Yes	No
Never drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Occasionally drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Frequently drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>

<b>If you drink alcohol currently or have done so in the past:</b>	
Number days drink/week	
Number drinks/day	
Number years quit	

<b>Employment:</b> Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is your occupation:
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<b>Support Systems:</b>	Yes	No
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live with your spouse, significant other, family or friends?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in your own house/apartment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in an assisted living environment?	<input type="checkbox"/>	<input type="checkbox"/>

Other comments:

**Transportation:**  
Would transportation to UCLA Health for daily treatments be difficult for you?  Yes  No  
If Yes, please explain:

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**System Review: Please check “yes” or “no” box to indicate if you have any of the following:**

	Yes	No		Yes	No
<b>Immunology/Allergy</b>			<b>Genitourinary (Female)</b>		
Allergies to animals or plants	<input type="checkbox"/>	<input type="checkbox"/>	Burning or painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Reactions (Runny Nose or itchy eyes)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>			Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat (arrhythmias)	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent night time urination	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking two blocks (dyspnea)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / bladder stones	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of hands, feet or ankles (edema)	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath while walking or lying down (orthopnea)	<input type="checkbox"/>	<input type="checkbox"/>	Urgency with urination	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur (palpitations)	<input type="checkbox"/>	<input type="checkbox"/>	Urine color change	<input type="checkbox"/>	<input type="checkbox"/>
<b>Constitutional</b>			Vaginal discharge/bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal spotting	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary (Male)</b>		
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Burning or painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy (sluggishness, sleepiness)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Malaise (uneasiness)	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Change: <input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	Frequent night time urination	<input type="checkbox"/>	<input type="checkbox"/>
If yes, amount: _____ lbs			Kidney / bladder stones	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>			Scrotal/testicular swelling	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Urgency with urination	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	Urine color change	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to hot/cold (thyroid disease)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic</b>		
<b>Ears, Nose &amp; Throat</b>			Abnormal bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain swallowing / Sore throat dysphagia)	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands (lymph nodes)	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin</b>		
Nose bleeding (epistaxis)	<input type="checkbox"/>	<input type="checkbox"/>	Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Change in hearing ability	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal itching (pruritus)	<input type="checkbox"/>	<input type="checkbox"/>
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Oral bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>		
Ear infection (otitis)	<input type="checkbox"/>	<input type="checkbox"/>	Inflammation of joints (arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection (sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>	Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sputum production	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Taste changes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing	<input type="checkbox"/>	<input type="checkbox"/>	Range of motion problems	<input type="checkbox"/>	<input type="checkbox"/>
Voice change	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>		
			Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>

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**System Review (continued): Please check “yes” or “no” box to indicate if you have any of the following:**

	Yes	No		Yes	No
<b>Ears, Nose &amp; Throat</b>			<b>Skin</b>		
Pain swallowing / Sore throat dysphagia)	<input type="checkbox"/>	<input type="checkbox"/>	Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal itching (pruritus)	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeding (epistaxis)	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Change in hearing ability	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>		
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Inflammation of joints (arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Oral bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection (otitis)	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection (sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sputum production	<input type="checkbox"/>	<input type="checkbox"/>	Range of motion problems	<input type="checkbox"/>	<input type="checkbox"/>
Taste changes	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>		
Ear ringing	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Voice change	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			<b>Respiratory</b>		
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Blood in sputum (hemoptysis)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive tearing (lacrimation)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological</b>		
Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	<input type="checkbox"/>
Excessive light sensitivity (photophobia)	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Other visual difficulties/changes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Gait problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>			Headaches		
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Recent change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Motor weakness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Fresh blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	Sensory problems	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Black stools	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			

Patient or Representative Signature \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ ID # \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_