UCLA Health System

MRN:
Patient Name:

(Patient Label)

PATIENT HEALTH QUESTIONNAIRE
Radiation Oncology

REVIEWED DATE / INITIALS									

SAFETY:	**YES**	**NO**
Are you at risk for falls?		
Do you have a Pacemaker?		
Females; Is there a possibility you may be pregnant?		

ALLERGIES:			
	YES	NO	
Do you have any allergies to medications?			If YES, please list medication allergies:
Are you allergic to iodine/IV contrast dye?			

PERTINENT HISTORY
Medical History (please list past and current conditions**):**

Medical Problems	Surgeries

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

	YES	NO
Inflammatory Bowel Disease		
Crohn's Disease		
Ulcerative Colitis		
Lupus		
Scleroderma		
Claustrophobia		

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Have you ever had:

	YES	NO
Previous Radiotherapy		
Previous Chemotherapy		

GYNECOLOGICAL (female patients only):

Number of pregnancies:	Have you ever taken oral contraceptives or hormone replacement medication?	YES	NO
Number of children:	If yes, what type:		
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: ☐ Premenopausal ☐ Postmenopausal ☐ Don't know			

FAMILY HISTORY

	YES	NO
Have any of your family members ever had cancer?		
If yes, please list relationship and type of cancer in your family member(s):		

SOCIAL HISTORY:

Smoking					
	YES	NO		**If you smoke currently or have smoked in the past:**	
Never smoked				Number years smoked	
Smoke currently				Number packs per day	
Smoked previously				Number years quit	

Alcohol					
	YES	NO		**If you drink alcohol currently or have done so in the past:**	
Never drink alcohol				Number days drink/week	
Occasionally drink alcohol				Number drinks/day	
Frequently drink alcohol				Number years quit	

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Employement: Are you employed? ☐ YES ☐ NO	If yes, what is your occupation:

Support Systems:	YES	NO
Do you live alone?		
Do you live with your spouse, significant other, family or friends?		
Do you live in your own house/appartment?		
Do you live in a nursing home?		
Do you live in an assisted living environment?		
Other comments:		

Transportation:
Would transportation to UCLA for daily treatments be difficult for you? ☐ YES ☐ NO
If Yes, please explain:

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

	YES	NO		YES	NO
Immunology/Allergy			**Genitourinary (Female)**		
Allergies to animals or plants			Burning or painful urination		
Reactions (Runny Nose or itchy eyes)			Frequent urination		
			Blood in urine		
Cardiovascular			Incontinence		
Irregular heart beat (arrythmias)			Frequent night time urination		
Chest Pain			Kidney / bladder stones		
Difficulty walking two blocks (dyspnea)			Sexual difficulty		
Swelling of hands, feet or ankles (edema)			Urgency with urination		
Shortness of breath while walking or lying down (orthopnea)			Urine color change		
			Vaginal discharge/bleeding		
Heart Murmur (palpitations)			Vaginal spotting		

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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
Constitutional			**Genitourinary (Male)**		
Poor appetite			Burning or painful urination		
Fatigue			Frequent urination		
Fevers			Blood in urine		
Lethargy (sluggisness, sleepiness)			Impotence		
Malaise (uneasiness)			Incontinence		
Night Sweats			Frequent night time urination		
Chills			Kidney / bladder stones		
Recent Weight Change: Gain ☐ Loss ☐			Scrotal/testicular swelling		
If yes, amount: _____lbs			Urgency with urination		
			Urine color change		
Endocrine					
Hot flashes			**Hematologic**		
Menstrual irregularities			Abnormal bruising or bleeding		
Intolerance to hot/cold (thyroid disease)			Swollen glands (lymph nodes)		
Ears, Nose & Throat			**Skin**		
Pain swallowing / Sore throat (dysphagia)			Blisters		
Ear pain			Abnormal itching (pruritus)		
Nose bleeding (epistaxis)			Rash		
Change in hearing ability					
Mouth dryness			**Musculoskeletal**		
Oral bleeding			Inflammation of joints (arthritis)		
Ear infection (otitis)			Bone Pain		
Sinus infection (sinusitis)			Joint Pain		
Excessive sputum production			Muscle weakness		
Taste changes			Range of motion problems		
Ear ringing					
Voice change					
Eyes			**Psychiatric**		
Blurred vision			Depression		
Double vision			Anxiety		
Excessive tearing (lacrimation)					
Night blindness			**Respiratory**		
Excessive light sensitivity (photophobia)			Cough		
Other visual difficulties / changes in vision			Blood in sputum (hemoptysis)		

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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
Gastrointestinal			**Neurological**		
Abdominal pain			Disorientation		
Recent change in bowel habits			Dizziness		
Constipation			Gait problems		
Frequent diarrhea			Headaches		
Heartburn or indigestion			Insomnia		
Fresh blood in stools			Memory loss		
Hemorrhoids			Motor weakness		
Black stools			Paralysis		
Nausea			Convulsions (seizures)		
Vomiting			Sensory problems		
			Stroke		

Patient Signature: _____ Date: _____ Time: _____

If completed by an individual other than the patient, please state relationship to the patient: _____

_____

This Past Medical History, Family History, Social History, and Review of Symptoms have been reviewed with the patient, by the physician(s) noted below:

Resident Signature: _____ Date: _____ Time: _____

Attending Signature: _____ Date: _____ Time: _____