Astera
RADIATION ONCOLOGY

9 Centre Drive, Suite 115
Monroe, NJ 08831
phone 609-655-5755 • fax 609-655-5725
www.PrincetonRadiationOncology.com

Patient Information

Today's Date: _____

Full Name (Last, First, MI): _____

Date of Birth: _____ □ Male □ Female

Last 4 numbers SSN: _____ □ I prefer not to provide

Address (Street, City, Zip code): _____

Email address: _____

Phone (check preferred contact): □ Home _____ □ Cell _____

Employed: □ No □ Yes: Occupation _____ Work phone _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact Name: _____ Relationship _____ Phone_____

Race:

□ African American □ Caucasian □ Unknown □ Other _____
□ Asian □ Hispanic □ Decline to provide

Ethnicity:

□ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language:

□ English □ Spanish □ Other _____

List the physicians you would like to receive communication:

Name	**Specialty**	**Phone**

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Patient Name: _____ **Date:** _____

Do you have an Advanced Directive (Living Will)? □ Yes □ No

Do you have a previous diagnosis of cancer? □ No □ Yes, type/year:

_____

Medical Problems	**Surgery: Type and date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check any Medical Devices / Implants:

□ Pacemaker □ Infusion Port □ Dialysis access / catheter
□ Defibrillator □ Insulin pump □ VP Shunt

Date of last Flu vaccine: _____ **Date of Pneumococcal vaccine:** _____

Do you currently, or, have you ever smoked or used tobacco? □ No □ Yes
If Yes, type _____ How much per day _____ # of years _____ Year quit _____

Do you drink alcohol? □ No □ Yes If Yes, what kind _____ How many drinks per day _____

Were you ever exposed to any occupational hazards (such as asbestos, chemicals, coal dust)?

_____

FEMALE PATIENTS ONLY:

Last mammogram: _____ **Last Bone Density Scan:** _____

Last pap smear: _____ **Age of menses:** _____ **Age at menopause:** _____

Age at 1st pregnancy: _____ **Number of pregnancies:** _____ **Number of Deliveries:** _____

History of hormone replacement therapy □ No □ Yes If yes, how many years? _____

History of oral contraceptive use? □ No □ Yes If yes, how many years? _____

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Patient Name: _____ **Date:** _____

Medications: Please list any medications you are taking at this time (including hormones and vitamins)

☐ Check if copy of medication list is attached

Medication	**Dose**	**How often**	**How taken (oral/injection/topical)**

Pharmacy Name: _____ Pharmacy Phone: _____

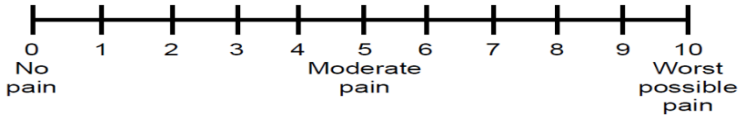
Pharmacy Address: _____

Do you have a latex allergy? ☐ No ☐ Yes **Do you have an allergy to IV contrast?** ☐ No ☐ Yes

Do you have any medication allergies? ☐ No ☐ Yes - please list below:

Medication Allergy	**Reaction**

Pain Rating - If you have pain, where is it located? _____



Nursing Notes (For Office Use Only):

_____

_____

_____

RN initials _____

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Patient Name: _____ **Date:** _____

Review of Systems: *Please check any symptoms you are currently experiencing:*

Constitutional
□ Fatigue
□ Fever
□ Chills
□ Night sweats
□ Difficulty Sleeping
□ Weight loss >10 lbs.
□ Weight gain >10 lbs.

Head and Neck
□ Hearing changes
□ Eye pain
□ Ear pain
□ Oral sores
□ Dry Mouth
□ Change in voice
□ Sore throat
□ Difficulty swallowing
□ Jaw pain

Skin
□ Itching
□ Rashes
□ New or changed mole
□ Unhealed sores
□ Nail changes
□ Change in skin color

Cardiovascular
□ Chest pain
□ Palpitations
□ Dizziness or fainting
□ Leg swelling

Respiratory
□ Shortness of breath
□ Wheezing
□ Cough
□ Coughing up blood

Gastrointestinal
□ Loss of appetite
□ Indigestion/heartburn
□ Bloating
□ Abdominal pain
□ Nausea/vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding
□ Incontinence
□ Date of last colonoscopy: _____

Neurological
□ Headaches
□ Visual changes
□ Dizziness
□ Memory loss
□ Confusion
□ Numbness/tingling
□ Muscle weakness
□ Unsteady gait

Lymphatics
□ Easy bruising
□ Swollen glands
□ Swelling of arm/leg

Endocrine
□ Increased thirst
□ Increased urination
□ Hair changes
□ Cold intolerance

Psychiatric
□ Anxiety
□ Depression

Musculoskeletal
□ Joint swelling
□ Muscle or joint pains
□ Back pain
□ Bone pain

Genitourinary
□ Frequent urination
□ Urinary urgency
□ Urinary burning
□ Blood in urine
□ Incontinence

GU - Male
□ Impotence
□ Testicular pain
□ Penile pain

Breast
□ Breast Mass
□ Breast Pain
□ Nipple Discharge

Have any members of your family (blood relatives) had cancer? □ No □ Yes, please list:

Relationship	Cancer	If deceased, age	Comments