



Patient Questionnaire

RADIATION ONCOLOGIST: Dr Brian Larson

Date: _____ **Referring Urologist** _____

Name: _____

Address: _____

Home Phone Number: _____

Work Phone (if applicable) _____

Cell Phone or Alternate Number: _____

Date of Birth: _____

HT. _____ **WT.** _____ **Age:** _____

Dx: Prostate Cancer

Date of diagnosis: _____

Gleason score: _____

PSA: _____

Bx. positive: _____

Prostate volume: _____

Hormone therapy: Yes No

Are you **currently** experiencing any of the following symptoms? **Please select Yes / No**

CONSTITUTIONAL

ENDOCRINE

Fever Y / N

Excessive Thirst Y / N

Chills Y / N

Fatigue Y / N

Headache Y / N

EYES

GASTROINTESTINAL

Blurred Vision Y / N

Abdominal Pain Y / N

Blindness Y / N Nausea / Vomiting Y / N

NEUROLOGIC

CARDIOVASCULAR

Tremors Y / N

Varicose Veins Y / N

Seizures Y / N

Chest Pain Y / N

INTEGUMENTARY

MUSCULOSKELETAL

Skin Rash Y / N

Joint Pain Y / N

Itching Y / N

Back Pain Y / N

HEENT

RESPIRATORY

Sinus Problems Y / N

Cough Y / N

Sore Throat Y / N

Shortness of Breath Y / N

HEMATOLOGIC

Blood Clotting Problems Y / N

Swollen Glands Y / N

Weight Loss Y / N

Check any **personal** significant illness:

Heart Disease Yes No If Yes Explain:_____

Heart Valve Disease Yes No If Yes
Explain:_____

Lung Disease Yes No If Yes
Explain:_____

Gastrointestinal Disease Yes No If Yes
Explain:_____

Glaucoma Yes No If Yes Explain:_____

High Blood Pressure Yes No If Yes
Explain:_____

Diabetes Yes No If Yes Explain:_____

Stroke Yes No If Yes Explain:_____

Bleeding Problems Yes No If Yes
Explain:_____

Cancer Yes No If Yes Explain:_____

Anesthetic Problems Yes No If Yes
Explain:_____

Weight Loss Yes No If Yes Explain:_____

Prior Radiation Treatment Yes No If Yes
Explain:_____

Other (List) Yes No If Yes Explain:_____

List all past surgeries (including date) _____

Medications: _____

Allergies: Drug Class: Iodine Penicillin Sulfa Contrast Dye

Food Class: Dairy (Lactose) Eggs Nut Oils

Shellfish Strawberries Wheat

Other: Bee Venom Latex Pet Dander

Pollen Mold Surgical Tape Other _____

Check any **family history** of illness:

Heart Disease Yes No If Yes,
Who: _____

Lung Disease Yes No If Yes,
Who: _____

High Blood Pressure Yes No If Yes,
Who: _____

Diabetes Yes No If Yes,
Who: _____

Stroke Yes No If Yes, Who: _____

Bleeding Problems Yes No If Yes,
Who: _____

Cancer Yes No If Yes, Who: _____

Anesthetic Problems Yes No If Yes,
Who: _____

Kidney Stones Yes No If Yes,
Who: _____

Other (list)

Social history:

Tobacco use: Cigarettes: Y / N Quit: Y / N How Long Ago (years): _____

Cigars: Y / N **Quit:** Y / N **How Long Ago (years):**_____

Pipe: Y / N **Quit:** Y / N **How Long Ago (years):**_____

Smokeless: Y / N **Quit:** Y / N **How Long Ago (years):**_____

Alcohol use: No Occasionally Weekly Daily

Controlled Substance: (List All and Frequency)_____

Current or Former Occupation:_____

Contact with Any Known Carcinogens? _____

Any Additional Information, Questions, or Notes:

