UCLA Health

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	If YES, please list medication allergies:
Do you have any allergies to medications?	☐	☐	
Are you allergic to iodine/IV contrast dye?	☐	☐	

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? ☐ Yes ☐ No
o If YES, how many cycles have you completed?
o If YES, date of last chemo dose:
o Please list the names of chemo drugs you received:

Cancer History

Type	Yes	No	Type	Yes	No	Type	Yes	No
Bladder	☐	☐	Esophageal	☐	☐	Skin	☐	☐
Bone	☐	☐	Leukemia	☐	☐	Small Intestine	☐	☐
Brain	☐	☐	Lung	☐	☐	Stomach	☐	☐
Breast	☐	☐	Ovarian	☐	☐	Uterine	☐	☐
Cervical	☐	☐	Pancreatic	☐	☐	Other – Specify		
Colon	☐	☐	Prostate	☐	☐	_____		

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Medical History:

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Depression	☐	☐	Myocardial Infarction	☐	☐
Anemia	☐	☐	Diabetes Mellitus	☐	☐	Nerve/Muscle Disease	☐	☐
Anxiety	☐	☐	Emphysema	☐	☐	Osteoporosis	☐	☐
Arthritis	☐	☐	GERD	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Sickle Cell Anemia	☐	☐
Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Cataracts	☐	☐	HIV/AIDS	☐	☐	Substance Abuse	☐	☐
CHF	☐	☐	Hypertension	☐	☐	Thyroid Disease	☐	☐
Clotting Disorder	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
COPD	☐	☐	Meningitis	☐	☐	Ulcers	☐	☐
Other Medical History:								

Surgical History:

	Yes	No		Yes	No
Appendectomy	☐	☐	Cholecystectomy	☐	☐
Back Surgery	☐	☐	Hysterectomy	☐	☐
Other Surgical History:					

Do you have any of the specific medical conditions listed below:	Yes	No
Inflammatory Bowel Disease	☐	☐
Crohn's Disease	☐	☐
Ulcerative Colitis	☐	☐
Lupus	☐	☐
Scleroderma	☐	☐
Claustrophobia	☐	☐

Have you ever had:	Yes	No
Previous Radiotherapy	☐	☐
Previous Chemotherapy	☐	☐

Gynecological (female patients only):

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

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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
Never smoked	☐	☐
Smoke currently	☐	☐
Smoked previously	☐	☐

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

Alcohol	Yes	No
Never drink alcohol	☐	☐
Occasionally drink alcohol	☐	☐
Frequently drink alcohol	☐	☐

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

Employment: 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/apartment?	☐	☐
Do you live in a nursing home?	☐	☐
Do you live in an assisted living environment?	☐	☐
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
Immunology/Allergy		
Allergies to animals or plants	☐	☐
Reactions (Runny Nose or itchy eyes)	☐	☐
Cardiovascular		
Irregular heart beat (arrhythmias)	☐	☐
Chest Pain	☐	☐
Difficulty walking two blocks (dyspnea)	☐	☐
Swelling of hands, feet or ankles (edema)	☐	☐
Shortness of breath while walking or lying down (orthopnea)	☐ ☐	☐ ☐
Heart Murmur (palpitations)	☐	☐
Constitutional		
Poor appetite	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Lethargy (sluggishness, sleepiness)	☐	☐
Malaise (uneasiness)	☐	☐
Night Sweats	☐	☐
Chills	☐	☐
Recent Weight Change: ☐ Gain ☐ Loss If yes, amount: _____lbs	☐	☐
Endocrine		
Hot flashes	☐	☐
Menstrual irregularities	☐	☐
Intolerance to hot/cold (thyroid disease)	☐	☐
Ears, Nose & Throat		
Pain swallowing / Sore throat dysphagia)	☐	☐
Ear pain	☐	☐
Nose bleeding (epistaxis)	☐	☐
Change in hearing ability	☐	☐
Mouth dryness	☐	☐
Oral bleeding	☐	☐
Ear infection (otitis)	☐	☐
Sinus infection (sinusitis)	☐	☐
Excessive sputum production	☐	☐
Taste changes	☐	☐
Ear ringing	☐	☐
Voice change	☐	☐

	Yes	No
Genitourinary (Female)		
Burning or painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Frequent night time urination	☐	☐
Kidney / bladder stones	☐	☐
Sexual difficulty	☐	☐
Urgency with urination	☐	☐
Urine color change	☐	☐
Vaginal discharge/bleeding	☐	☐
Vaginal spotting	☐	☐
Genitourinary (Male)		
Burning or painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Impotence	☐	☐
Incontinence	☐	☐
Frequent night time urination	☐	☐
Kidney / bladder stones	☐	☐
Scrotal/testicular swelling	☐	☐
Urgency with urination	☐	☐
Urine color change	☐	☐
Hematologic		
Abnormal bruising or bleeding	☐	☐
Swollen glands (lymph nodes)	☐	☐
Skin		
Blisters	☐	☐
Abnormal itching (pruritus)	☐	☐
Rash	☐	☐
Musculoskeletal		
Inflammation of joints (arthritis)	☐	☐
Bone Pain	☐	☐
Joint Pain	☐	☐
Muscle weakness	☐	☐
Range of motion problems	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐

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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
Eyes			**Respiratory**		
Blurred vision	☐	☐	Cough	☐	☐
Double vision	☐	☐	Blood in sputum (hemoptysis)	☐	☐
Excessive tearing (lacrimation)	☐	☐	**Neurological**		
Night blindness	☐	☐	Disorientation	☐	☐
Excessive light sensitivity (photophobia)	☐	☐	Dizziness	☐	☐
Other visual difficulties/changes in vision	☐	☐	Gait problems	☐	☐
Gastrointestinal			Headaches		
Abdominal pain	☐	☐	Insomnia	☐	☐
Recent change in bowel habits	☐	☐	Memory loss	☐	☐
Constipation	☐	☐	Motor weakness	☐	☐
Frequent diarrhea	☐	☐	Paralysis	☐	☐
Heartburn or indigestion	☐	☐	Convulsions (seizures)	☐	☐
Fresh blood in stools	☐	☐	Sensory problems	☐	☐
Hemorrhoids	☐	☐	Stroke	☐	☐
Black stools	☐	☐			
Nausea	☐	☐			
Vomiting	☐	☐			

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 _____