Welcome to the Radiation Oncology Department. Please take a moment to help us better understand your present medical information. Kindly place a check next to each condition that pertains to you. Please elaborate when you speak with your clinical team.

### General Condition
- **Fatigue** [ ]
- **Fever/Night Sweats** [ ]
- **Chills** [ ]
- **Weight Change** [ ]
- **Other:** ________________________

### Head & Throat
- **Vision Changes** [ ]
- **Difficulty Swallowing** [ ]
- **Ear Pain** [ ]
- **Nose Bleeds** [ ]
- **Sore Throat** [ ]
- **Problems with Hearing** [ ]
- **Dry Mouth** [ ]
- **Mouth Sores** [ ]
- **Sinus Infections** [ ]
- **Altered Taste** [ ]
- **Tinnitus** [ ]
- **Other:** ________________________

### Neck
- **Neck Masses** [ ]
- **Muscle Weakness** [ ]
- **Neck Pain** [ ]
- **Decreased Range of Motion** [ ]
- **Swelling in Neck** [ ]
- **Other:** ________________________

### Skin
- **Hair Loss** [ ]
- **Bruises** [ ]
- **Dry Skin** [ ]
- **Nail Changes** [ ]
- **Itching** [ ]
- **Rash** [ ]
- **Other:** ________________________

### Breast
- **Breast Mass** [ ]
- **Nipple Discharge** [ ]
- **Breast Pain** [ ]
- **Other:** ________________________

### Heart
- **Irregular Rhythm** [ ]
- **Chest Pain** [ ]
- **Swelling of Legs** [ ]
- **Palpitations** [ ]
- **Other:** ________________________

### Respiratory
- **Cough** [ ]
- **Shortness of Breath** [ ]
- **Coughing up Blood** [ ]
- **Wheezing** [ ]
- **Other:** ________________________

### Gastrointestinal
- **Abdominal Pain** [ ]
- **Change in Bowel Habits** [ ]
- **Heartburn** [ ]
- **Nausea/Vomiting** [ ]
- **Rectal Bleeding** [ ]
- **Hemorrhoids** [ ]
- **Other:** ________________________

### Genitourinary
- **Burning on Urination** [ ]
- **Frequency of Urination** [ ]
- **Blood in Urine** [ ]
- **Incontinence** [ ]
- **Kidney Stones** [ ]
- **Problems w/Sexual Function** [ ]
- **Vaginal Discharge** [ ]
- **Other:** ________________________

### Neurologic
- **Confusion** [ ]
- **Dizziness** [ ]
- **Headache** [ ]
- **Insomnia** [ ]
- **Memory Loss** [ ]
- **Seizure** [ ]
- **Stroke** [ ]
- **Other:** ________________________

### Emotional
- **Mood Swings** [ ]
- **Depression** [ ]
- **Hallucinations** [ ]
- **Other:** ________________________

### Endocrine
- **Diabetes** [ ]
- **Hot Flashes** [ ]
- **Thyroid Problems** [ ]
- **Other:** ________________________

### Allergies
- **Latex** [ ]
- **Iodine** [ ]
- **IV Dye** [ ]
- **Seafood** [ ]
- **Food Items** [ ]

### Drug Allergies: List
- **None**

### Medications: List
- **None**

Patient Signature: ____________________________  Date: _____________  Time: _____________