auckland radiation oncology

Ph: 09 623 6046 Email: reception@aro.co.nz

Name: (Last Name) (First Name)

NHI: **DOB:**

Gender:

PATIENT HEALTH HISTORY

Date: / /

Weight: kg Height: cm

1 Do you have any allergies or sensitivities to any medications, food, latex, sticking plasters or other? ***Please list below*** Y ◯ N ◯

Allergy Name	Type of Reaction

2 Do you take any regular medications? *(Including the contraceptive pill, inhalers, herbal remedies, pain medication, eye-drops, sprays or regular over-the-counter medications such as aspirin)*

Please list below Y ◯ N ◯

Medication	Strength (mg)	Dose (how many)	Frequency (how often)

3 Mobility:
Independent ◯ Using Equipment ◯ Requiring Assistance ◯ Completely Dependent ◯

Do you suffer from or have you ever had any of the following? *Please answer all the questions*

4 Heart problems (eg. heart attack, angina, irregular pulse, fluid on lungs, **PACEMAKER,** rheumatic fever, palpitations, fainting, murmur, endocarditis)? Y ◯ N ◯

If yes, please list:

5 Diabetes? Y ◯ N ◯

Continuous glucose monitor? Y ◯ N ◯ *Tablets* Y ◯ N ◯ *Insulin* Y ◯ N ◯

6 Are you, or could you, be pregnant? Y ◯ N ◯

7 Have you had any joint replacement surgery? Y ◯ N ◯

If yes, which joints:

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Name: _____
(Last Name) (First Name)

NHI: _____

8 Hepatitis A ◯ Hepatitis B ◯ Hepatitis C ◯ Yellow Jaundice ◯ HIV ◯
MRSA ◯ VRE ◯ CRE ◯

9 High blood pressure? Y ◯ N ◯
If yes, is this being monitored/treated by your GP?

10 A stroke (e.g. CVA, or TIA)? Y ◯ N ◯

11 Blood clots to legs or lungs? Y ◯ N ◯

12 Blood disorders: (e.g. anaemia, Von Willebrands disease)? Y ◯ N ◯
If yes, please explain:

13 Lung problems (e.g. asthma, recent bronchitis, emphysema, TB)? Y ◯ N ◯

14 Arthritis? Y ◯ N ◯

15 Fits or seizures (eg. epilepsy)? Y ◯ N ◯
If yes, when was your last seizure?

16 Any other medical conditions? Y ◯ N ◯
If yes, please specify:

17 Do you live alone? Y ◯ N ◯

18 Do you have caring responsibilities for others at home? Y ◯ N ◯

19 Have you ever smoked? Y ◯ N ◯
If no, go to question 21

20 Do you currently smoke? Y ◯ N ◯
If yes, how many a day, for how many years and how long ago?

21 Do you drink alcohol? Y ◯ N ◯
If yes, how much and how often?

22 Do you take street drugs or narcotics other than those prescribed for you? Y ◯ N ◯
If yes, please describe:

23 Do you have any vision or hearing difficulties? Y ◯ N ◯
If yes, please describe:

24 Do you have any skin problems (e.g. ulcers, bruise easily, wounds or dressings)? Y ◯ N ◯
If yes, please describe:

25 Do you have any religious beliefs/practices or cultural needs we should be aware of? Y ◯ N ◯
If yes, please describe: