AUCKLAND RADIATION ONCOLOGY
A partnership between MercyAscot and Southern Cross Hospitals
Ph: 09 623 6046 Email: reception@aro.co.nz

Name: (Last Name) (First Name)

NHI: DOB:

Gender: Male ○ Female ○

PATIENT HEALTH HISTORY

Date: / /

Weight: kg Height: cm

Do you have any allergies or sensitivities to any medications, food, latex, sticking plasters or other? Y ○ N ○

Medication/Substance Name	Type of Reaction

1. Have you ever smoked? Y ○ N ○
   If no, go to question 3
2. Do you currently smoke? Y ○ N ○
   If yes, how many a day, for how many years and how long ago?
3. Do you drink alcohol? Y ○ N ○
   If yes, how much and how often?
4. Do you take street drugs or narcotics other than those prescribed for you? Y ○ N ○
   If yes, please describe:
5. Do you have any vision or hearing difficulties? Y ○ N ○
   If yes, please describe:
6. Do you have any religious beliefs/practices or cultural needs we should be aware of? Y ○ N ○
   If yes, please describe:
7. Do you have any skin problems (eg. ulcers, bruise easily, wounds or dressings)? Y ○ N ○
   If yes, please describe:
8. Mobility:
   Independent ○ Using Equipment ○ Requiring Assistance ○ Completely Dependent ○
9. 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)* ***List Below***

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

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Name: _____
(Last Name) (First Name)

NHI: _____

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

10 Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Yellow Jaundice ☐ HIV ☐

11 Hiatus Hernia ☐ Heartburn ☐ Acid Reflux ☐

12 High blood pressure? Y ○ N ○
If Yes, is this being monitored/treated by your GP?

13 Heart problems (eg. heart attack, angina, irregular pulse, fluid on lungs, **PACEMAKER**, rheumatic fever, palpitations, fainting, murmur, endocarditis)? Y ○ N ○
If Yes, please list:

14 A stroke (eg. CVA, or TIA)? Y ○ N ○

15 Blood clots to legs or lungs? Y ○ N ○

16 Blood disorders: (eg. anaemia, Von Willebrands disease)? Y ○ N ○
If Yes, please explain:

17 Lung problems (eg. asthma, recent bronchitis, emphysema, TB)? Y ○ N ○

18 Arthritis? Y ○ N ○

19 Fits or seizures (eg. epilepsy)? Y ○ N ○
If Yes, when was your last seizure?

20 Diabetes? Y ○ N ○
If Yes, what treatment are you on? Diet Tablets Insulin

21 Are you, or could you, be pregnant? Y ○ N ○

22 Have you had any joint replacement surgery? Y ○ N ○
If Yes, which joints:

23 Any other medical conditions? Y ○ N ○
If Yes, please specify:

Discharge Planning

24 Do you live alone? Y ○ N ○

25 Do you have caring responsibilities for others at home? Y ○ N ○

26 Would you like to be given information about cancer support services? Y ○ N ○