EASTERN RADIOLOGISTS
INTERVENTIONAL RADIOLOGY

2090-A W Arlington Blvd, Greenville, NC 27834
Mon–Fri 7:45am–4pm
252.754.5253 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

CONSULT: ONCOLOGY

Physician: _____ Oncologist: _____

Surgical Oncologist: _____ Radiation Oncologist: _____

What type of cancer do you have:_____

When were you diagnosed: _____

What treatments have you had: chemotherapy surgery radiation

Describe your treatment(s): _____

_____

_____

If you have liver tumors, have you been evaluated for a liver transplant? YES NO
Have you been experiencing confusion or excessive sleepiness? YES NO
Have you experienced swelling or excess fluid in your abdomen? YES NO

How do you rate your current level of activity: select one

___ I am fully active, able to carry out all household and personal care activities without restriction including strenuous activities.

___ I am able to carry out work of a light or sedentary nature, e.g., light house or office work but unable to do sustained strenuous activity.

___ I am capable of all selfcare but unable to carry out any household or work activities, I am up and about more than 50% of waking hours.

___ I am capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.

___ I cannot carry on any selfcare, I am totally confined to bed or chair.

What medical conditions do you have: Please circle

High blood pressure	Heart disease	Atherosclerosis	Stroke	Diabetes
Bile duct obstruction	Bile duct stents	Hepatitis B or C	Kidney disease	COPD

Other: _____

Have you had a Whipple procedure: YES NO

What other surgeries have you had: _____

_____

What medicines do you take: _____

_____

List any medicines or other things you are allergic to: _____

_____

Do you have a family history of cancer? If yes please describe: _____

Where do you work? If you are retired describe your previous job: _____

_____

Do you smoke: YES NO If yes how many packs/day:_____

Do you drink alcohol, beer, or wine? YES NO

Are you experiencing any of the following symptoms today? Please circle all that apply

fever /chills	weight loss	decreased appetite	fatigue
rash	itching	easy bruising	jaundice
hearing loss	vision changes	decreased vision	sore throat
shortness of breath	cough	wheezing	bloody cough
chest pain	palpitations	weakness on exertion	leg swelling
nausea/vomiting	constipation	bloody stool	diarrhea
painful urination	bloody urine	decreased urination	incontinence
dizziness	weakness	headache	paralysis
speech changes	confusion	loss of coordination	tremor
joint pain	joint swelling	numbness or tingling	stiffness
anxiety	depression	thoughts of suicide	memory loss
poor sleep