Radiation Medicine
Consult Intake Questionnaire

Frederick Health

PATIENT NAME _____ DATE OF BIRTH _____ MR# _____

1. Please describe your pain level on a scale between 1 and 10 (1= low, 10=high): _____

   Where is your pain located? _____

   List current pain medications, if any: _____

2. Current level of fatigue: ☐ **Minimum** ☐ **Moderate** ☐ **Severe**

3. Current appetite: ☐ **Good** ☐ **Fair** ☐ **Poor** Recent change in weight: _____

4. Difficulty breathing? ☐ **Yes** ☐ **No**

   Lying flat over a period of time? ☐ **Yes** ☐ **No** Details: _____

5. Digestive/Bowel Difficulties: ☐ **Yes** ☐ **No** Details: _____

6. Urinary Difficulties: ☐ **Yes** ☐ **No** Details: _____

7. Coordination/Ambulation/Balance Difficulties: _____

8. Mental/Emotional Difficulties: ☐ **Anxiety** ☐ **Depression** ☐ **Claustrophobia** ☐ **Memory**

   Details: _____

9. Implanted Devices: ☐ **Pacemaker** ☐ **CGM** ☐ **Power Port** ☐ **Other:** _____

10. Have you ever received radiation therapy? ☐ **Yes** ☐ **No**

    What area of your body was treated? _____

    What facility provided the treatment? _____

    What are the dates (approximate) that you received treatment? _____

    Additional details: _____

11. Chief Complaint: _____

_____

_____

EMPLOYEE _____ DATE/TIME _____