<Full Name>
<Patient Id 1>

PATIENT QUESTIONNAIRE

1) Have you ever had radiation treatments before? ☐ Yes ☐ No
(Cobalt, Radium, Implants, X-Ray Therapy)

If yes, when and where?

_____

To what area of the body was the treatment given?

_____

2) Have you ever been seen by <u>any of the radiation oncologist</u> in the department?
☐ Yes ☐ No

Dr. Paul Monsour
Dr. Siddhartha Padmanabha

If yes, when, where, and by whom?
_____

_____

3) Do you have a pacemaker? ☐ Yes ☐ No

4) Have you ever had any chemotherapy? ☐ Yes ☐ No

If yes, when did it start? _____

When was your last course? _____

ADDITIONAL COMMENTS:

_____

_____

Patient's Signature Date

_____ _____