INITIAL NURSING ASSESSMENT
Radiation Oncology

Patient Name: ________________________ Date of Birth: __________ Today's Date: __________
Occupation: ________________________ Family Present: ________________________
Diagnosis: ________________________ Physician referred by: ________________________
Physicians: ____

Height: _____ Weight: _____ Pain (0 None – 10 Worst Pain): _____ Site: _________ Describe: ____________

HISTORY OF PRESENT ILLNESS:

Chief Complaint: ____
____

Prior radiation therapy? ☐ No ☐ Yes, Site treated: ______________ Facility: ______________
Prior records available? ☐ No ☐ Yes, ________________________________
Prior chemotherapy? ☐ No ☐ Yes, Last treatment: ______________ Facility: ______________
Prior hormonal therapy? ☐ No ☐ Yes, Last treatment: ______________ Facility: ______________

ALLERGIES (list medication/reaction): ________________________________
____

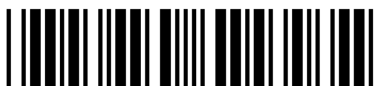
PAST MEDICAL HISTORY (please list all):

Major Medical Problems: ____
____

Prior Surgeries: ____
____

Family History of Cancer: ____
____

SOCIAL HISTORY/HABITS:
Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced
Lives with: ____
Fluent English? ☐ No ☐ Yes Primary Language: ______________
Interpreter Needed? ☐ No ☐ Yes, Interpreter: ______________
Do you suffer from insomnia? ☐ No ☐ Yes
Do you use (require) a sleep aid? ☐ No ☐ Yes
Do you consume alcohol? ☐ No ☐ Yes, Drinks per day? ______________
Quit Date: __________ Describe treatment (if any): ______________
Have you used tobacco? ☐ No ☐ Yes, # of years? __________ Packs per day? __________
Quit Date: __________ Assistance needed to abstain? ☐ No ☐ Yes
Do you use recreational drugs? ☐ No ☐ Yes, Type: ______________



REVIEW OF SYTEMS:

CONSTITUTIONAL Fatigue ☐ No ☐ Yes Fatigue Level (1-5): ____________ KPS (RN to complete): ____________ Fevers ☐ No ☐ Yes	Night Sweats ☐ No ☐ Yes Weight loss ☐ No ☐ Yes, ____ lbs _____months Sudden weight gain ☐ No ☐ Yes, ____ lbs
EYES Blurred vision ☐ No ☐ Yes Cataracts ☐ No ☐ Yes Glaucoma ☐ No ☐ Yes	Blindness ☐ No ☐ Yes: Right / Left / Both Require glasses ☐ No ☐ Yes Require contacts ☐ No ☐ Yes
EARS, NOSE, MOUTH, THROAT Hearing loss ☐ No ☐ Yes If yes: Right / Left / Both Hoarseness ☐ No ☐ Yes Difficulty swallowing ☐ No ☐ Yes	Hearing aid(s) ☐ No ☐ Yes Dentures/Partials ☐ No ☐ Yes: Upper / Lower / Both Dental problems ☐ No ☐ Yes Requires consult ☐ No ☐ Yes
CARDIOVASCULAR/RESPIRATORY Heart attack ☐ No ☐ Yes Stroke ☐ No ☐ Yes Angina ☐ No ☐ Yes Pacemaker/AICD ☐ No ☐ Yes High blood pressure ☐ No ☐ Yes Cough ☐ No ☐ Yes Asthma ☐ No ☐ Yes	Shortness of breath ☐ No ☐ Yes: Oxygen @ _____ L/min Unable to lay flat ☐ No ☐ Yes Sleep apnea ☐ No ☐ Yes Coughing up blood ☐ No ☐ Yes Emphysema/COPD ☐ No ☐ Yes Asbestos exposure ☐ No ☐ Yes
GASTROINTESTINAL Nausea ☐ No ☐ Yes Vomiting ☐ No ☐ Yes Constipation ☐ No ☐ Yes Diarrhea ☐ No ☐ Yes Blood in stool ☐ No ☐ Yes Hemorrhoids ☐ No ☐ Yes	Jaundice ☐ No ☐ Yes Liver disease ☐ No ☐ Yes Hiatal hernia ☐ No ☐ Yes Heartburn ☐ No ☐ Yes Ulcer ☐ No ☐ Yes Feeding tube ☐ No ☐ Yes # ____ cans of ____________ per day
GENITOURINARY Burning with urination ☐ No ☐ Yes Blood in urine ☐ No ☐ Yes Frequent urination ☐ No ☐ Yes Urgency to urinate ☐ No ☐ Yes Urinary incontinence ☐ No ☐ Yes **Male:** Prostate problems ☐ No ☐ Yes	**Female:** Vaginal itch/discharge ☐ No ☐ Yes If yes, describe: ________________ Hormone replacement therapy ☐ No ☐ Yes, # of Years: ____ Last menstruation: ________________ Menopause ☐ No ☐ Yes, at Age: _______ Number of pregnancies: ________________ Number of live births: ________________ Age at first pregnancy: ________________

REVIEW OF SYSTEMS (continued)

INTEGUMENTARY

Rashes ☐ No ☐ Yes, Location: ____________________
Healing incisions ☐ No ☐ Yes, Location: ____________________
Sores/Wounds ☐ No ☐ Yes, Location: ____________________
New mass(es) ☐ No ☐ Yes, Location: ____________________
Swelling ☐ No ☐ Yes, Location: ____________________
IV Access Device ☐ No ☐ Yes, Type: ____________________
History of skin cancer ☐ No ☐ Yes, Location: __________ and Type: __________

NEUROLOGICAL/PSYCHIATRIC

Headaches ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Seizures ☐ No ☐ Yes, Frequency: __________
Dizziness ☐ No ☐ Yes
Fainting ☐ No ☐ Yes
Numbness ☐ No ☐ Yes, Location: __________
Tingling ☐ No ☐ Yes, Location: __________

Confusion: ☐ No ☐ Yes
Memory: ☐ Good ☐ Fair ☐ Poor

Learning Preference:
☐ Written ☐ Verbal ☐ Video

Barriers:
☐ No ☐ Yes, Specify: __________

ALLERGIC/IMMUNOLOGIC

Autoimmune disorder ☐ No ☐ Yes, Type: __________
Seasonal allergies ☐ No ☐ Yes
Allergies to food ☐ No ☐ Yes, Specify: __________

Allergies to medication ☐ No ☐ Yes
If yes, specify: __________
Other allergies ☐ No ☐ Yes
If yes, specify: __________

MUSCULOSKELETAL

Fall risk ☐ No ☐ Yes
Balance difficulty ☐ No ☐ Yes
Weakness ☐ No ☐ Yes

Arthritis ☐ No ☐ Yes, Location: __________
Assistive device ☐ No ☐ Yes, Type: __________
Generalized weakness ☐ No ☐ Yes, Site: __________

Movement of extremities:
☐ Normal ☐ Decreased in Right / Left upper extremities ☐ Decreased in Right / Left lower extremities
Activities of Daily Living: ☐ No limits ☐ Needs dressing assistance ☐ Needs meal assistance

ENDOCRINE

Diabetes ☐ No ☐ Yes
Insulin dependent ☐ No ☐ Yes
Thyroid disorder ☐ No ☐ Yes

HEMATOLOGIC

Anemia ☐ No ☐ Yes
Bleed easily ☐ No ☐ Yes
Infection requiring isolation ☐ No ☐ Yes
Type (if known): __________

PAIN

Area of pain: ____________________
Cause of pain: ____________________
Quality (describe pain): ____________________
Does the pain radiate (where): ____________________
Time of onset: ____________________ Intensity Level (**0=no pain 10=worst pain**): ______
What relieves the pain? ____________________

Patient has problems with: ☐ Child care ☐ Spiritual issues ☐ Financial issues ☐ Transportation
Explain: ____________________

Completed By: ____________________

Advance Directive: ☐ Yes ☐ No ☐ Pamphlet given ☐ Copy received
Video: ☐ Yes ☐ No ☐ N/A
Discussed: ☐ MSW ☐ Coordinator
Reviewed by RN: ____________________ **Date:** __________ **Time:** __________