Valley Radiology CONSULTANTS

PARKWAY ON ELM
255 N. Elm Street, Suite 100
Escondido, CA 92025
T (760) 739-5400 F (760) 739-8440

Name: _____MRN: _____ DOB: _____

Have you ever been diagnosed with cancer? ( ) Yes ( ) No

--If so, which cancer (cancers) & which body part (parts)? When was your diagnosis?

Cancer/Body Part _____ Date of diagnosis _____

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--Have you received any of the following treatments for your cancer or cancers?

Surgery _____ Dates _____

Radiation Therapy _____ Dates _____

Chemotherapy _____ Dates _____

Bone Marrow Stimulation Meds _____ Dates _____

Hormone Therapy _____ Dates _____

Immunotherapy _____ Dates _____

Last time you had something to eat or drink besides water _____

Do you have diabetes? ( ) Yes ( ) No

--If so, do you take insulin? ( ) Yes ( ) No Date/Time of Last Dose _____

--If so, do you take Metformin or Glucophage? ( ) Yes ( ) No Last dose _____

--If so, are you on an insulin pump? ( ) Yes ( ) No

Any recent surgeries or biopsies (last 6 months)? ( ) Yes ( ) No

--If so, what body part and date? _____

Any recent injury, trauma, or fall (last 6 months)? ( ) Yes ( ) No

--If so, please provide details and dates _____

Any recent illness, infection, or dental work (last 6 months)? ( ) Yes ( ) No

--If so, please provide details and dates _____

Are you pregnant or nursing? ( ) Yes ( ) No

Drug allergies _____

Current medications _____