Stereotactic Radiosurgery Institute

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Providing Services at: The Rotating Gamma System Institute, Gurnee, IL, Advanced Radiation Oncology Center, Gurnee, IL, Vista Health Care, Waukegan, IL, Victory Memorial Hospital, Waukegan, IL, St. Francis Hospital, Evanston, IL

PLEASE FILL IN THIS FORM AND SEND TO ABOVE ADDRESS WITH THE MOST RECENT IMAGING STUDIES.

Stereotactic Radiosurgery Institute Questionnaire

Patient Name:	
Today's Date:	
Patient Date of Birth:	
Patient Social Security Number:	
Patient Contact Name:	
Patient Contact Relationship to Patient:	
Patient Contact Telephone Number:	
Patient Contact Mailing Address:	
Main Complaint (The problem that the patient is being evaluated for presently):	
What problems led to the diagnosis (Please list dates of each problem)?	

Patient Name:	
What problems is the patient having now (Weakness, numbness, seizures, etc.)?	
Does the patient have claustrophobia?	
Is the patient working? (Circle one)	Full Time Part Time Not Working
If the patient is not working, did they stop because of the illness?	
If the patient is not working, when did they stop working?	
Is the patient walking? (Circle one)	Independently With a Cane With a Walker With Assistance Self Transfer to Wheel Chair Bedridden with Full Assisted Transfer to Wheel Chair

Patient Name:	
Is the patient able to communicate well? (Circle one)	Normally Has some problems understanding Has some problems expressing themself Has severe problems understanding Has severe problems expressing themself No communication possible
How is the patient's memory? (Circle one)	Normal Somewhat Impaired Very Poor
What is the patient's level of awareness? (Circle one)	Alert and Normal Sleepy but can initiate conversation Sleepy and only responds to stimulation briefly In a coma
Is the patient able to take care of their Personal Self Care? (Circle one)	Alone without help With Some Assistance With Major or Full Assistance
How is the patient's personality? (Circle one)	Normal Affected

Patient Name:	
Please list the patient's medications (Name, Dose, and Frequency):	
Please list any allergies or adverse reactions to medications:	
Please list any medical problems:	Heart: Lung: Digestive: Other:
Please list dates and previous surgeries performed:	
Please list dates and location (brain, lung, etc.) of any radiation therapy delivered, doctor who treated patient, and address:	
Please list dates of any chemotherapy and list tumor treated with the chemotherapy:	
Please list dates of scans and angiograms performed and where they were done. Also list the results of the scans if you know them. (Attach report copies if available)	
Attach Pathology Reports if available	