RADIOTHERAPIE
STRAHLENTHERAPIE
Zentrum für Radio-Strahlentherapie
PRAXIS BERLIN

Dr. med. Geetha Sreenivasa
Specialist of Radiotherapy

Priv.-Doz. Dr. med. Roland Jacob
Specialist of Radiology and Radiotherapy

Karl-Marx-Allee 90 A • 10243 Berlin
Phone: 030 / 224 880 04
Fax: 030 / 224 880 05
e-mail: info@radio-strahlentherapie.de
www.radio-strahlentherapie.de

PATIENT'S INFORMATION SHEET BEFORE PAIN TREATMENT WITH LOW DOSE IRRADIATION

Dear patient,

Please fill in this form carefully and completely and return it to our reception staff. According to the indicated information the physician will perform a treatment adapted to your pain situation. If you already have read this information sheet on our website, please bring it with you filled out.

Name	First name	Date of birth
Street, number	Zip code, place	Country
Phone (private)	Phone (mobile)	
e-mail		
Referring physician	Specialization	

1	What is the diagnosis on your referral?
2	Are there any other diseases known? Please mark appropriate boxes. ☐ High blood pressure ☐ Diabetes (☐ with insulin therapy) ☐ Cancer ☐ Heart disease ☐ Thyroid diseases ☐ Fainting spells ☐ Gastritis/gastroesophageal reflux ☐ Gout ☐ Epilepsy ☐ Renal dysfunction Other:

Location Radiotherapy
Karl-Marx-Allee 90A
10243 Berlin
Phone 030 224 880 04
Fax 030 224 880 05

Location Administration
Goslarer Platz 7
10589 Berlin
Phone 030 327 980 92 50
Fax 030 327 980 97

3

Learned profession: _____ Your professional status: _____

Previous operations: month/year and part of body

Do you wear a cardiac pacemaker? ○ No ○ Yes

4

In which body part do you currently feel pains?	Since when do you feel pains?

5

How would you describe the quality of pain?

☐ burning ☐ with numbness ☐ dull ☐ stabbing

☐ while resting ☐ also at night-time ☐ with overstrain

Please describe intensity of pain on a numeric scale:

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

none mild medium strong very strong strongest imaginable pain

6

Which painkillers do you currently take?

name of drug	dose in milligram (mg)	morning	midday	evening
		☐	☐	☐
		☐	☐	☐

7

Do you take further drugs?

Name of drug	dose in milligram (mg)	morning	midday	evening
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

8	How was your pain treated before?		
	☐ physiotherapy	☐ shock wave therapy	☐ joint injections
	☐ ultrasound	☐ operations	☐ painkillers
	☐ cortisone pulse-therapy	☐ acupuncture	☐ electric stimulation therapy
	☐ TENS therapy	☐ radiosynovectomy	☐ other therapy:
9	Have you already received a radiation treatment? ○ no ○ yes If so, which part of the body was irradiated and when?		
10	Was an X-ray, CT or MRI scan performed? If so, please bring the images along to the consultation.		
	month/year	body part	type of examination
11	Height (cm)	Weight (kg)	Notes (e.g., intentional/unintentional weight loss in the last 6 months)
12	**For women** Are you pregnant or might you be pregnant? ○ No, I am not pregnant and I am not expecting a pregnancy in the next months ○ Yes, I am pregnant or might be pregnant Last mammography was performed in the year _____ ○ inconspicuous ○ conspicuous ○ no examination performed yet		

I hereby confirm that the information referred to above is true and correct.

Date: _____ Signature: _____

This information sheet in German can be found under the following link:
http://radio-strahlentherapie.de/fuer-patienten/formulare/