

New Patient Questionnaire

Thank you for taking a few minutes to complete this history form. It will help your new doctor focus on the problems that have brought you here for this appointment and allow more time for you to get your questions and concerns fully addressed.

Cancer Specialists treat many different diseases. We understand that not all the questions in this form will apply to you. Please try to answer all the questions to the best of your knowledge and write "N/A" for "not applicable" if you feel a particular question does not apply to you. We realize that this is an extensive questionnaire and we appreciate your time in completing it so that we are better able to address your questions.

Please answer as many questions as possible and ask your nurse or doctor if there are questions that you are unsure about.

Date of Visit ___/___/___ Date of Birth ___/___/___ Age _____

Patient Name _____ MR # _____

Address _____

Email address _____

Visit Information:

Who is with you today?

What is your diagnosis?

When were you diagnosed? _____ At which hospital? _____

What physician referred you to our clinic?

What is your understanding of why you are being seen today?
 Consultation 2nd Opinion Treatment/follow-up

Do you want to see or were you referred to a specific Oncologist? Yes No

If yes, which Oncologist?

Describe how your illness started, how it was diagnosed, and what has happened up to now:

Physician Information: Please provide the names and contact information (office address, phone, fax, specialty, or hospital affiliation) for all of the doctors involved in your care.

Specialty	Physician Name Address/ Hospital Affiliation	Phone	Fax
Family M.D./ Primary Care/ Internist:			
Medical Oncologist:			
Radiation Oncologist:			
Surgeon:			
Gynecologist:			

Gynecological/Obstetric History – Women Only	Yes	No	
Age that you started menstruating:			Date of last menstrual period:
Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	Date:
Were your ovaries removed?	<input type="checkbox"/>	<input type="checkbox"/>	Date:
Have you gone through menopause?	<input type="checkbox"/>	<input type="checkbox"/>	How old were you?
Do/did you use oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	How long? When stopped:
Do/did you use hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>	How long? When stopped:
Have you had gynecological or breast changes?	<input type="checkbox"/>	<input type="checkbox"/>	Explain:
Number of pregnancies:			Number of live births:
			Age at first full term pregnancy:
Could you be pregnant at this time?	<input type="checkbox"/>	<input type="checkbox"/>	
What is your bra and cup size? (<i>breast cancer patients only</i>)			

Past Medical History: (Please check all that apply)	Yes	No	Describe
Other cancers?	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular			
• High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
• High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
• Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	
• Heart attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>	Date (year): _____
• Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	
• Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Date (year): _____
• Blood clots/Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory			
• Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine			
• Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal			
• Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
• Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
• Liver disease/cirrhosis/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
• Irritable Bowel/Crohn's/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	
• Bowel Disease (polyps)	<input type="checkbox"/>	<input type="checkbox"/>	
• Other stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	

Past Medical History - continued: (Please check all that apply)	Yes	No	Describe
Genitourinary			
• Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	
• Gynecological problems/HPV	<input type="checkbox"/>	<input type="checkbox"/>	
• Prostate problems/BPH/prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	
• Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal			
• Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
• Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune			
• Rheumatoid Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic			
• Epilepsy/seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	
• Parkinson's/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	
• Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
• Bipolar/Schizophrenia/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Other diseases?	<input type="checkbox"/>	<input type="checkbox"/>	

History of Surgery or other Procedures		<input type="checkbox"/> No prior surgeries/ procedures
Date of surgery/procedure	Type of surgery/procedure	Hospital/clinic where performed

Do you have an Internal Electronic Device, i.e. defibrillator, pacemaker? Yes No
 If yes, please have your card ready at the time of consultation for the nurse and doctor.

Health Maintenance		
Men and Women		
Have you had a sigmoidoscopy or colonoscopy?	<input type="checkbox"/> Yes, Date _____	<input type="checkbox"/> No
Has your doctor checked your stool for blood?	<input type="checkbox"/> Yes, Date _____	<input type="checkbox"/> No
Have you had your skin checked?	<input type="checkbox"/> Yes, Date _____	<input type="checkbox"/> No
Have you had an oral/dental exam?	<input type="checkbox"/> Yes, Date _____	<input type="checkbox"/> No

Allergies: Include medications/food/environmental <input type="checkbox"/> No known allergies	
Allergy	Describe reaction

Social History	
Where were you born? (state or country)	
What is your race/ ethnicity?	
What type of work did/do you do:	Retired <input type="checkbox"/>
Marital Status:	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
With whom do you live?	
Do you have children?	Yes <input type="checkbox"/> No <input type="checkbox"/> List ages:
Do you drink alcohol?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of drinks per week:	If you used to drink, when did you stop?
Do you use tobacco products now or in the past? (cigars, cigarettes, tobacco)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of years: _____	Number of packs per day: _____ When did you quit? _____
Are you interested in information regarding smoking cessation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use recreational drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>	What drug(s)? How often?
Do you have special religious, spiritual, or cultural needs we need to be aware of: If yes, please explain:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have Advanced Directives (living will, power of attorney for health care)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, could you provide a copy for your records?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you like more information about obtaining Advanced Directives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(Office use only): If yes, referral made to:	

Family History: Please list any cancer or blood disease your family members have had. If you do not know exact ages, please estimate.

Family member	Current age	Age at diagnosis	Age at death	Type of cancer/ blood disease
Yourself				
<i>Your siblings (Please circle either sister or brother)</i>				
Sister	Brother			
Sister	Brother			
Sister	Brother			
Sister	Brother			
Sister	Brother			
<i>Your children (Please circle either daughter or son)</i>				
Daughter	Son			
Daughter	Son			
Daughter	Son			
Daughter	Son			
Daughter	Son			
<i>Your Father's Family (Please circle either Aunt or Uncle)</i>				
Father				
Paternal Grandfather				
Paternal Grandmother				
Aunt	Uncle			
Aunt	Uncle			
Aunt	Uncle			
Aunt	Uncle			
Other				
Other				
Other				
<i>Your Mother's Family (Please circle either Aunt or Uncle)</i>				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Aunt	Uncle			
Aunt	Uncle			
Aunt	Uncle			
Aunt	Uncle			
Other				
Other				
Other				

Review of Systems: (Please circle all that apply)	Describe
General: weight loss, weight gain, always tired, weak, night sweats, fevers, chills	<input type="checkbox"/> No Problem
Skin: rash, change in moles, sores, lumps, itching, or hives	<input type="checkbox"/> No Problem
Eyes: pain in eyes, watery eyes, dry eyes, blurred vision, double vision, or other change in vision	<input type="checkbox"/> No Problem
Ears/nose/throat: hearing loss, ringing in the ears, stuffy nose or congestion, frequent sinus infections or sinus pain, change in taste or smell, soreness in mouth or throat, hoarseness, swollen glands, dental problems, dentures or partials	<input type="checkbox"/> No Problem
Respiratory: dry cough, productive cough, shortness of breath with exertion, wheezing, coughing up blood, home oxygen (____ L/min)	<input type="checkbox"/> No Problem
Heart: chest pain, palpitations, pounding heart, swelling in legs/feet	<input type="checkbox"/> No Problem
Endocrine: excessive thirst, urination, or appetite, heat or cold intolerance, hot flashes	<input type="checkbox"/> No Problem
GI: abdominal pain, nausea, vomiting, heartburn or reflux, difficulty swallowing, diet restrictions, anorexia, constipation, diarrhea, change in bowel habits or incontinence, bright red blood in stools or dark tarry stools	<input type="checkbox"/> No Problem
GU: frequent urination, urgency with urination, difficulty starting stream or weak stream, pain or burning with urination, blood in urine, waking at night to urinate, urinary incontinence, vaginal bleeding, prostate problems or impotence	<input type="checkbox"/> No Problem
Blood/Lymphatic: anemia, easy bruising or bleeding, lymphedema or swelling, vascular access device (port/pic)	<input type="checkbox"/> No Problem
Infectious Disease: frequent infections or recent exposure to infectious disease	<input type="checkbox"/> No Problem
Musculoskeletal: Joint pain or swelling, muscle or bone pain, difficulty moving arms or legs, pain with walking	<input type="checkbox"/> No Problem
Neurologic: headaches, fainting, dizzy spells or vertigo, numbness or tingling, poor balance, memory loss, forgetfulness, confusion, changes in mood, focal weakness, paralysis, depression, anxiety or seizures	<input type="checkbox"/> No Problem
Do you have a recent history of falls? Assistive devices you use: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Crutches	Describe how fall occurred: <input type="checkbox"/> No Falls

Pain Scale										
If you are currently having pain, please rate your pain by drawing a circle around the number on the scale that best describes your pain.										
0	1	2	3	4	5	6	7	8	9	10
(no pain)			(moderate pain)					(most severe pain)		
Where is your pain located?										
How long have you had this pain?										
Are you taking medication for your pain? Yes <input type="checkbox"/> No <input type="checkbox"/>										
If yes, what medication(s)?										
Does the medication help your pain? Yes <input type="checkbox"/> No <input type="checkbox"/>										
(Office use only): Karnofsky Score _____%										

Personal Contact Information	
The clinic staff have permission to leave messages on answering machines or voice mails regarding possible future appointments at the following numbers:	
<input type="checkbox"/> Home	_____ Area Code _____ Number
<input type="checkbox"/> Cell	_____ Area Code _____ Number
<input type="checkbox"/> Work	_____ Area Code _____ Number
Best time for staff to phone: <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons	

Family or Caregiver Contact Information	
Due to the privacy regulations, we are unable to discuss your medical information without your permission. If you would like us to discuss your care with a significant other or family member, please provide the name, your relationship (spouse, son, daughter, friend), and a phone number for your contact person.	
Contact: _____	Relationship: _____ Phone: _____
Contact: _____	Relationship: _____ Phone: _____
We also encourage you to indicate a password that we will use to verify your identity and the identity of the person listed above.	
Password: _____	

Pharmacy Information

The clinic staff have permission to electronically prescribe my prescriptions and may request my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

My *preferred* pharmacy:

Name: _____

Address: _____

My 2nd preferred pharmacy:

Name: _____

Address: _____

My 3rd preferred pharmacy:

Name: _____

Address: _____

Please inform our clinic if your preferred pharmacy information changes.

THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.

Patient Signature: _____ **Date:** _____

RN Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Interpreter Signature (if applicable): _____ **Date:** _____

Physician Drawings/Diagrams

A large, empty rectangular box with a thin black border, intended for physician drawings or diagrams.