DCH Health System | Manderson Cancer Center

Patient Name: _____
DOB: _____ Date: _____
M# _____ Doctor: _____

NEW PATIENT INFORMATION

Reason for Visit (Conditions or Symptoms): _____
_____
(Please Mark One) New Patient: _____ Follow-Up Doctor: _____ Follow-Up Chemo: _____
Primary Medical Doctor: _____ Specialist Doctor: _____
Preferred Pharmacy: _____

Please list any Medications:

DRUG NAME	DOSE	FREQUENCY (HOW OFTEN)

Please list any Allergies and Adverse Drug Reactions (food allergies, drug allergies):

ALLERGY	DESCRIBE REACTION

Do you have a sensitivity or allergy to Latex: YES _____ NO _____ If yes, please select or describe below
☐ Band Aids/Tape ☐ Balloons ☐ Kitchen/Rubber Gloves ☐ Condoms and Diaphragms
☐ Clothing with Elastic ☐ Other Rubber Products: _____

MEDICAL HISTORY (check all that apply):
☐ Cancer ☐ High Cholesterol ☐ Blood Clot ☐ High Blood Pressure ☐ Diabetic ☐ Psychiatric Disorders ☐ Dialysis
☐ Emphysema/Asthma ☐ Restless Leg Syndrome ☐ Heart Disease ☐ Stroke/CVA ☐ Home Oxygen ____L/min
☐ Pacemaker ☐ Urinary Catheter
Please list other Medical History: _____
_____

PROCEDURE/SURGERY HISTORY (mark all that apply) – List Date Performed and Doctor's Name:

☐ Appendix: _____	☐ Back: _____	☐ Biopsy: _____
☐ CABG (Heart): _____	☐ Cardiac Stents: _____	☐ Colonoscopy/EGD:_____
☐ Colon Resection:_____	☐ C-Section: _____	☐ Gallbladder: _____
☐ Gastric Bypass: _____	☐ Hernia Repair:_____	☐ Joint Replacement: _____
☐ Hysterectomy: _____	☐ Mastectomy: _____	☐ Pacemaker: _____
☐ Tubal Ligation: _____	☐ Tonsillectomy: _____	☐ Other Operations (specify below)

_____
_____

Have you ever received:
Chemotherapy? ☐ Yes ☐ No If yes, where: _____
Radiation? ☐ Yes ☐ No If yes, where: _____

GYNECOLOGIC (Female Only):

Pregnancies: # of Births: _____ # of Pregnancies: _____ Age at first Birth: _____

Menstrual Cycle: Age Menstrual Cycle Started: _____ Last Cycle Date: _____ Cycle Length (days): _____

Menopause Status: ☐ Pre ☐ Peri ☐ Post ☐ Unknown ☐ No Answer Age of Menopause: _____

Menopause Reason: ☐ Natural ☐ Chemo ☐ Removal of Ovaries ☐ Other

Hormone Use: ☐ Any Hormone Use ☐ Over the Counter Products/# of years used: _____

☐ ost Menopause Use/# of years used: _____ ☐ Other Hormone Use/# of years used: _____

When was your last Pap Smear: _____ **When was your last Mammogram**: _____

FAMILY HISTORY (if unsure leave blank) – Has anyone had any of the following: Cancer, Stroke, Heart Disease, Diabetes, Hypertension or other medical condition.

	AGE	**AGE AT DEATH**	**MEDICAL HISTORY**
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)			

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____

Smoking: ☐ Never ☐ Yes – Occasional ☐ Yes – But Quit ☐ Yes – Current/Active

What age did you start smoking? _____ # packs per day: _____ Date Quit: _____

Alcohol: ☐ Never ☐ Yes – Occasional ☐ Yes – But Quit ☐ Yes – Active ☐ Social - # drinks per year: _____

drinks per day: _____ # days per week: _____ Date Quit: _____ _____

Products: ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Recreational Drug Use

☐ Other Petroleum Products ☐ Other: _____

Contact with Hazardous Materials: ☐ Contact ☐ No Contact ☐ Unknown

☐ Asbestos ☐ Benzene ☐ Lead ☐ Radiation

☐ Other Petroleum Products ☐ Other: _____

Support System:

Living Status: Do you live Locally? ☐ YES ☐ NO

☐ Lives with Spouse or Significant Other ☐ Lives Alone ☐ Lives with Family/Friend ☐ Incarcerated

☐ Lives in Own House ☐ Lives in a Nursing Home ☐ Lives in an Assisted Living Environment ☐ Homeless

Transportation/Support:

☐ Adequate Transportation Available for Expected Visits ☐ Transportation Problems Exist & requires assistance

☐ Supportive Family/Friends willing to assist with needs ☐ No Support System Exists to assist with needs

☐ Referred to Social Services for Assistance ☐ Has used a Home Health Care Agency ☐ _____

Do You Feel That You are a Victim of Abuse or Have Experienced any of the following? ☐ YES ☐ NO

☐ Elder Abuse / Neglect ☐ Domestic Abuse / Neglect ☐ Other: _____

Highest Level of Education Completed:

☐ Some High School ☐ High School/GED ☐ Technical/Occupational Certificate ☐ Associate Degree

☐ Some College Coursework ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate/Professional Degree

☐ Other (if not listed, please specify): _____

Activity:

☐ Sedentary ☐ Daily Activities ☐ Occasional Exercise ☐ Light Exercise ☐ Regular Exercise

☐ Extensive Exercise ☐ Other Exercise/Activity: _____

Check all that apply:

☐ History of Falling – Immediate or Within the Past 3 Months

☐ Use of Ambulatory Aid (please list type): _____

Nutrition (check all that apply):

☐ Regular Diet ☐ Diabetic Diet ☐ Liquid Diet ☐ Nutritional Supplements ☐ IV Nutrition

☐ Tube Feeding (please specify type): _____ ☐ Other: _____

Do you have difficulty with: ☐ Chewing ☐ Swallowing ☐ Neither

Weight:

☐ Gain - Please list the amount gained over the past 6 months _____

☐ Loss - Please list the amount lost over the past 6 months _____

- Is your weight loss: ☐ Intentional ☐ Unintentional

Do you have an IV access line?

☐ YES (if please specify what type below) ☐ NO

☐ Groshong ☐ Picc Line ☐ Mediport

Do you have an Advance Directive?

☐ YES (if yes, please bring a copy for your chart) ☐ NO

Do you need additional information regarding an Advance Directive (Living Will)?

☐ YES ☐ NO

Do you need a referral to meet with a:

Chaplain?

☐ YES ☐ NO

Social Worker?

☐ YES ☐ NO

Financial Counselor?

☐ YES ☐ NO

Pain:

On the scale to the right, 0 being absence of pain and 10 being the worst pain imaginable. Select the # that best represents your pain.	0 1 2 3 4 5 6 7 8 9 10 No Pain Worst Pain

Duration of Pain (in days, weeks, months, years): _____
Location of Pain: _____
Have you had any pain(s) in the recent past: _____
Present Pain Management and Effectiveness: _____
_____
_____

How does your pain effect/interfere with your activities of daily living:
☐ Function ☐ Sleep ☐ Appetite ☐ Relationships ☐ Emotions ☐ Concentration
☐ None ☐ Other (please specify): _____

PLEASE CHECK ANY OF THE PROBLEMS LISTED BELOW THAT YOU HAVE BEEN EXPERIENCING:

GENERAL: ☐ No Complaint ☐ Fever/Chills ☐ Night Sweats ☐ Weight Loss

EYES: ☐ No Complaint ☐ Double Vision ☐ Pain ☐ Blurred Vision

EARS: ☐ No Complaint ☐ Ringing ☐ Pain ☐ Discharge

NOSE: ☐ No Complaint ☐ Post Nasal Drip ☐ Discharge ☐ Bleeding

THROAT: ☐ No Complaint ☐ Pain ☐ Coating

LUNGS: ☐ No Complaint ☐ Cough ☐ Sputum ☐ Shortness ☐ Breath ☐ Pain with Breathing

HEART: ☐ No Complaint ☐ Chest Pain ☐ Shortness of Breath ☐ Feet Swelling ☐ Irregular Heart Beat

BLOOD: ☐ No Complaint ☐ Bleeding ☐ Bruising ☐ Enlarged Lymph Node

NEUROLOGIC: ☐ No Complaint ☐ Dizziness ☐ Numbness ☐ Weakness ☐ Headache

ABDOMEN: ☐ No Complaint ☐ Pain ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Dark or Bloody Stools

GYNECOLOGIC: ☐ No Complaint ☐ Menstrual Changes ☐ Pain/Cramping

GENITOURINARY: ☐ No Complaint ☐ Pain ☐ Difficulty Urinating ☐ Blood in Urine

MUSCOLOSKELETAL: ☐ No Complaint ☐ Pain ☐ Stiffness ☐ Decreased Movement ☐ Weakness

SKIN: ☐ No Complaint ☐ Bruising ☐ Rash ☐ Worrisome Growth ☐ Itching

BREAST: ☐ No Complaint ☐ Lactation (Breast Feeding) ☐ Pain ☐ Mass ☐ Nipple Discharge

ENDOCRINE: ☐ No Complaint ☐ Hot flashes or night sweats ☐ Cold or heat intolerance
☐ Excessive urination ☐ Excessive thirst

PSYCHIATRIC: ☐ No Complaint ☐ Delusions ☐ Hallucinations ☐ Mood Swings ☐ Depression
☐ Suicidal Thoughts ☐ Homicidal Thoughts

Patient (or Responsible Party) Signature: _____ Date: _____
Nurse Signature: _____ Date: _____