ALTUS CANCER CENTER™

Patient Label

New Patient Information Form

Dear Patient: Please take a few minutes to complete this form. Your answers will help the doctors and staff plan and provide your care. If you are unsure of any answers, leave the area blank. We will review this form with you after you complete it. Thank you for your cooperation and assistance.

Name: _____ **Date:** _____ **Time:** _____

Temperature: _____ **Pulse:** _____ **Resp:** _____ **BP:** _____ **HT:** _____ **WT:** _____

Person Completing This Form: ☐ Patient ☐ Other _____ (Relation to patient)

Primary Care Physician: _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Do you need a translator?

Educational Background: Highest grade completed: _____ ☐ College ☐ Post Graduate

Do you have an Advance Directive? ☐ Yes ☐ No **Do you have a Power of Attorney?** ☐ Yes ☐ No

Religion: Baptist ___ Catholic ___ Methodist ___ Jewish ___ Muslim ___ Jehovah Witness ___ Other_____

Any problem with your vision? ☐ Yes ☐ No **Any problem with your hearing?** ☐ Yes ☐ No

What is your medical reason for seeing the doctor?

Please briefly tell us about your current problem (when it started; symptoms; treatment)

How did you hear about our center? Referral from physician _____

Family or friend ____ TV ad ____ Radio ad _____ Billboard ____ Internet _____ Other_____

Have you ever been treated for cancer? ☐ No ☐ Yes _____

Have you ever received radiation other than routine x-rays?

☐ No ☐ Yes (When? _____ Where? _____)

Have you ever had a blood transfusion?

☐ No ☐ Yes (When? _____ Where? _____)

Have you ever received chemotherapy?

☐ No ☐ Yes (When? _____ Where? _____)

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Past Medical History: Please check all previous illnesses and list year of onset					
√	Year	Description	√	Year	Description
		Heart Problems			Cancer - Type:
		Heart Attack			Skin Cancer
		High Blood Pressure			Thyroid Problems
		Diabetes			Stomach Problems (GERD, ulcers, other)
		Circulation Problems			Liver Problems
		Stroke			Pancreas Problems
		Asthma			Hemorrhoids
		Emphysema/COPD			Seizures
		Tuberculosis			Migraine Headaches
		Breast Problems			Cataracts
		Prostate Problems			Blood Clots in Legs
		Kidney or Urine Problems			HIV/ AIDS
		Urine leaks			Ulcerative colitis, Cohn's disease, or other inflammatory bowel disease.
		Others:			

Surgical History: Please check all previous surgeries and list year of procedure					
√	Year	Description	√	Year	Description
		Tonsils Removed			Appendix Removed
		Esophagus/Hiatus Hernia			Small Intestine
		Stomach Surgery			Colon or Rectum
		Gallbladder			Hemorrhoid removal
		Pancreas			Hysterectomy
		Liver			Heart
		Breast			Prostate
		Cataracts			Biopsy

Other surgeries:

Date	Operation	Doctor	Hospital

Vaccination History:

Last Influenza Vaccine: _____	**Last Pneumonia Vaccine:** _____

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Last Colonoscopy: _____	Last Mammogram: _____	Last Pap Smear: _____

Obstetric/Gynecologic History

How many times have you been pregnant? How many babies have you had?

How many miscarriages or terminations have you had? Age at 1st birth:

Was any pregnancy complicated? ☐ Yes ☐ No If yes, describe:

Menstrual Cycle: What age started? Date last cycle: Age at Menopause:

Menopause Reason:

Have had a hysterectomy? ☐ Yes ☐ No If yes, why/when? _____

If yes, were your ovaries also removed? ☐ Yes ☐ No

Have you ever breast fed? ☐ Yes ☐ No If yes, number of times?

Have you ever or are you now taking any hormone or birth control pills? ☐ Yes ☐ No

If yes, When? _____ Name of hormone pill: _____:

Reason for Stopping Hormone pills:_____

Family History of Cancer

Relative	Cancer Type	Age at Diagnosis	Living? Y/N	Cause of death	Age at death
Father			Y N		
Mother			Y N		
Son(s)/Daughter(s)			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
Other Relatives					
Mother Side	Father Side		Y N		
			Y N		
			Y N		
			Y N		
			Y N		

Social History

With whom do you live? _____

Are you: ☐ employed, ☐ retired, ☐ disabled, ☐ other: _____

Describe your job or indicate your job title: _____

Do you personally receive home health care? ☐ Yes ☐ No If yes, which agency? _____

Do you smoke? ☐ Yes ☐ No

If yes, how much and for how long? _____

If you have quit, how long has it been? _____

How much and for how long did you smoke before you quit? _____

Do you use smokeless tobacco? ☐ Yes ☐ No How much and for how long? _____

Do you use illegal drugs? ☐ Yes ☐ No What and for how long? _____

Do you drink alcohol? ☐ Yes ☐ No How much and for how long? _____

If you have quit, how long has it been? _____

Describe your daily activities:

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Review of Systems: Check all problems that you are having now		
General: ☐ Fever –chills ☐ Sweats ☐ Change in sleep habits	☐ **No Symptoms** ☐ Weight Changes ☐ Pain ☐ Fatigue	To Be Completed By Medical Team
Psychological: ☐ Anxious ☐ Other	☐ **No Symptoms** ☐ Depressed	
Neurological: ☐ Memory changes ☐ Dizziness/fainting ☐ Blurred vision	☐ **No Symptoms** ☐ Numbness/ tingling ☐ Headache ☐ Seizures	
Head and Neck: ☐ Nose bleeds ☐ Problems swallowing ☐ Lesions in mouth or throat	☐ **No Symptoms** ☐ Hoarseness ☐ Sore throat	
Cardiovascular: ☐ Leg pain/ swelling ☐ Fast heart beat	☐ **No Symptoms** ☐ Chest pain	
Respiratory: ☐ Wheezing ☐ Short Breath	☐ **No Symptoms** ☐ Cough ☐ Bloody phlegm	
Breast: ☐ Lumps ☐ Changes	☐ **No Symptoms** ☐ Pain ☐ Nipple discharge	
Gastrointestinal: ☐ Constipation ☐ Blood in stools ☐ Indigestion ☐ Nausea/vomiting ☐ Yellow skin or eyes	☐ **No Symptoms** ☐ Change appetite/ diet ☐ Cramping ☐ Diarrhea ☐ Black stools	
Genitourinary: ☐ Burning ☐ Blood in urine ☐ Unable to control bladder	☐ **No Symptoms** ☐ Frequency ☐ Dribbling	
Musculoskeletal: ☐ Swelling ☐ Stiffness	☐ **No Symptoms** ☐ Joint/ back pain ☐ Trauma/ falls	
Skin: ☐ Open Sore ☐ Abnormal color ☐ Change in moles	☐ **No Symptoms** ☐ Rashes ☐ Pain	
Endocrine: ☐ Swelling	☐ **No Symptoms** ☐ Joint/ back pain	
Hematology: ☐ Abnormal bleeding ☐ Easy bruising	☐ **No Symptoms** ☐ Swelling/groin/armpit/neck ☐ Prior transfusion	

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Is there anything else you would like us to know about yourself or your visit with us today?

Patient Signature:

_____
Signature

_____
Printed Name

_____
Date

or Guardian / Surrogate Signature:
(If you have medical POA, please provide a copy)

_____
Signature

_____
Printed Name

_____
Date