

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: <input type="checkbox"/> Patient <input type="checkbox"/> Other _____ (Relation to patient)
Who referred you to see our doctors? _____
Primary Care Physician: _____
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Do you need a translator?
Educational Background: Highest grade completed: _____ <input type="checkbox"/> College <input type="checkbox"/> Post Graduate
Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No
Religion: Baptist ___ Catholic ___ Methodist ___ Jewish ___ Muslim ___ Jehovah Witness ___ Other _____
Any problem with your vision? <input type="checkbox"/> Yes <input type="checkbox"/> No Any problem with your hearing? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes _____

Have you ever received radiation other than routine x-rays? <input type="checkbox"/> No <input type="checkbox"/> Yes (When? _____ Where? _____)
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Have you ever had a blood transfusion? <input type="checkbox"/> No <input type="checkbox"/> Yes (When? _____ Where? _____)

Have you ever received chemotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes (When? _____ Where? _____)

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 1 st birth: _____	
Was any pregnancy complicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____		
Menstrual Cycle: What age started? _____	Date last cycle: _____	Age at Menopause: _____
Menopause Reason: _____		
Have had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why/when? _____ If yes, were your ovaries also removed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever breast fed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of times? _____		
Have you ever or are you now taking any hormone or birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> employed, <input type="checkbox"/> retired, <input type="checkbox"/> disabled, <input type="checkbox"/> other: _____
Describe your job or indicate your job title: _____
Do you personally receive home health care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency? _____
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No How much and for how long? _____
Do you use illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No What and for how long? _____
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How much and for how long? _____
If you have quit, how long has it been? _____
Describe your daily activities: _____

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

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