THE University of Vermont CANCER CENTER

MRN

Name

DOB

New Patient Evaluation

Please complete this form and bring to your appointment.

Name: _____ Your Phone Number: _____

Address: _____ E-mail: _____

_____ Your Age: _____

Referring Physician: _____ Your Date of Birth: _____

Primary Care Physician: _____ Marital Status: _____

Other (doctors you would like notes sent to): _____ Today's Date: _____

Source of Referral: ☐ Self ☐ MD _____ ☐ Other _____

Do you work outside the home? ☐ Yes ☐ No

Advanced Directives for Health Care

Are you aware of Advance Directives for Health Care (living will, durable power of attorney, etc.)? ☐ Yes ☐ No

If yes, have you completed Advance Directives for your health care? ☐ Yes ☐ No

If yes, would you be willing to bring a copy to put in your chart? ☐ Yes ☐ No

If no, would you like information about this? ☐ Yes ☐ No

Present Illness

Diagnosis (or reason for coming): _____

_____

When was this first noticed? _____ By whom? ☐ Myself ☐ Health Professional

Medical History

Do you have a Cardiac Pacemaker? ☐ Yes ☐ No

Do you have an Implantable Defibrillator? ☐ Yes ☐ No

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No **If yes**, how many packs per day: _____ # of Years Smoked? _____

If no, are you a former smoker? ☐ Yes ☐ No Packs per day? _____

Number of years smoked? _____ Year that you quit: _____

Alcohol Use: ☐ Yes ☐ No Drinks per day: _____

Medical Problems (like high blood pressure, diabetes, etc.): _____

_____

_____

Surgical Operations	Year	Type

Prior Cancer Treatment

Have you ever had chemotherapy before? ☐ Yes ☐ No

Have you ever had radiation therapy before? ☐ Yes ☐ No

Have you ever had cancer surgery before? ☐ Yes ☐ No

Gynecological History

Age at which you began to have menstrual periods: _____ Are you having regular menstrual cycles? ☐ Yes ☐ No

Number of pregnancies:_____Number of deliveries:_____Age at first childbirth: _____

Date of last menstrual period: _____ Date of last GYN exam: _____

Are you currently going through menopause? ☐ Yes ☐ No

If you have gone through menopause, how did it occur? ☐ Naturally ☐ Surgically

Have you had: ☐ Hysterectomy with removal of both ovaries ☐ Hysterectomy but both ovaries remain

Have you ever taken fertility drugs? ☐ Yes ☐ No Type_____Duration _____

Have you ever taken birth control pills? ☐ Yes ☐ No Type_____Duration _____

Have you ever taken hormone replacement therapies? ☐ Yes ☐ No Type_____Duration _____

Have you ever taken anti-estrogen therapies? ☐ Tamoxifen ☐ Arimidex ☐ Other _____

How long? ☐ Less than 1 year ☐ 1 – 2 years ☐ 3 or more years

New Patient Evaluation

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to surgical tape? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No **If yes**, list the medication and the type of allergy/reaction below:

Medication	Allergic Reaction

Pain

Do you currently have pain? ☐ Yes ☐ No Where? _____

Do you take pain medication? ☐ Yes ☐ No

If yes, does it control your pain? ☐ Yes ☐ No ☐ Certainly ☐ Partially

What other things help control the pain (ex. massage, heat, etc.)? _____

Please rate (circle) the worst pain you have had in the last 24 hours (0 = no pain, 10 = worst pain you have ever had):

0 1 2 3 4 5 6 7 8 9 10

Personal and Social History

Place of Birth: _____

Education (high school, college, etc.): _____

Do you work outside the home? ☐ Yes ☐ No ☐ Retired Type of work: _____

Are you currently? ☐ Single ☐ Married/Civil Union ☐ Widowed ☐ Divorced ☐ Domestic Partner

How many people live with you in your household? _____ # of Children: _____ Ages: _____

Review of Systems

Do you currently have any problem with anything mentioned below? **If yes**, please describe.

Fever/Chills/Sweats	☐ Yes ☐ No	
Fatigue (tiredness)	☐ Yes ☐ No	
Weight loss	☐ Yes ☐ No	
Loss of Appetite	☐ Yes ☐ No	
Eyes	☐ Yes ☐ No	
Ear/Nose/Throat	☐ Yes ☐ No	
Mouth Sores	☐ Yes ☐ No	
Heart (chest pain, other)	☐ Yes ☐ No	
Lungs (cough, breathing)	☐ Yes ☐ No	
Nausea	☐ Yes ☐ No	
Vomiting	☐ Yes ☐ No	
Diarrhea	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Bladder (urination)	☐ Yes ☐ No	
Muscle/Bones	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Numbness/Tingling	☐ Yes ☐ No	
Muscle Weakness	☐ Yes ☐ No	
Diabetes/Thyroid	☐ Yes ☐ No	
Blood Clots/Bleeding	☐ Yes ☐ No	
Swollen Glands	☐ Yes ☐ No	
Lumps or Masses (bunches)	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	
Other (specify)	☐ Yes ☐ No	

Cancer Family History

Have you ever been diagnosed with cancer? □ Yes □ No
Have you or any of your relatives ever had genetic testing? □ Yes □ No
Do you have any cancer in your family ("blood relative")? □ Yes □ No

	Type(s) of Cancer	Age(s) at Diagnosis	Current Age
You			

Immediate Family	**Total Number**	**Number with Cancer**	**Type(s) of Cancer**	**Age(s) at Diagnosis**	**Current Age**	**Age at Death**
Your Daughter(s)						
Your Son(s)						
Your Brother(s)						
Your Sisters(s)						

Paternal Relatives	**Type(s) of Cancer**	**Age(s) at Diagnosis**	**Current Age**	**Age at Death**	**Ethnic Background**
Your Father					
Your Father's Mother					
Your Father's Father					

	Total Number	**Number with Cancer**	**Type(s) of Cancer**	**Age(s) at Diagnosis**	**Current Age**	**Age at Death**
Your Father's Sister(s)						
Your Father's Brother(s)						
Your Paternal Cousins						

Maternal Relatives	Type(s) of Cancer	Age(s) at Diagnosis	Current Age	Age at Death	Ethnic Background
Your Mother					
Your Mother's Mother					
Your Mother's Father					

	Total Number	Number with Cancer	Type(s) of Cancer	Age(s) at Diagnosis	Current Age	Age at Death
Your Mother's Sister(s)						
Your Mother's Brother(s)						
Your Maternal Cousins						

Relative's Relationship to you (i.e niece, nephew, etc)	Type(s) of Cancer	Age(s) at Diagnosis	Current Age	Age at Death

Other comments and /or family medical history you feel would be relevant:

_____

_____

_____

_____

Current Medications – If you have not brought your own list: Please list ALL PRESCRIPTION and NON-PRESCRIPTION drugs including vitamins, herbs, etc.

Name	Dose	Frequency