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

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	

THE University of Vermont CANCER CENTER

MRN

Name

DOB

New Patient Evaluation

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