

Name

DOB

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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:	Address:	Please complete thi	s form and bring to your appointment.
Referring Physician:	Referring Physician:	Name:	Your Phone Number:
Referring Physician: Your Date of Birth:	Referring Physician: Your Date of Birth: Primary Care Physician: Marital Status: Other (doctors you would like notes sent to): Today's Date: Today's Date: Source of Referral: Self MD_ Other 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 no, 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): Medical History Do you have a Cardiac Pacemaker? Yes No No No 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:	Address:	E-mail:
Primary Care Physician: Marital Status:	Primary Care Physician: Marital Status:		Your Age:
Other (doctors you would like notes sent to):	Other (doctors you would like notes sent to):	Referring Physician:	Your Date of Birth:
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Do you have a Cardiac Pacemaker?	Do you have a Cardiac Pacemaker?	Diagnosis (or reason for coming):	
Do you have a Cardiac Pacemaker?	Do you have a Cardiac Pacemaker?	When was this first noticed?	By whom? Myself Health Professional
Do you have an Implantable Defibrillator?	Do you have an Implantable Defibrillator?	Medical History	
Do you smoke?	Do you smoke?		
If no, are you a former smoker?	If no, are you a former smoker?	How would you describe your general health	? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Number of years smoked?Year that you quit: Alcohol Use: \[Yes \] No Drinks per day:	Number of years smoked?Year that you quit: Alcohol Use: \[Yes \] No Drinks per day:	Do you smoke?	how many packs per day:# of Years Smoked?#
Alcohol Use: Yes No Drinks per day:	Alcohol Use: Yes No Drinks per day:	If no, are you a former smoker?	Yes No Packs per day?
· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	Number of years smoked?Year the	nat you quit:
Medical Problems (like high blood pressure, diabetes, etc.):	Medical Problems (like high blood pressure, diabetes, etc.):	Alcohol Use: Yes No Drinks per day	<i>y</i> :
		Medical Problems (like high blood pressure, o	diabetes, etc.):





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New Patient Evaluation		Page 2 of 7
Surgical Operations	Year	Туре
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	er of deliver	ries:Age at first childbirth:
Date of last menstrual period:	Da	ate of last GYN exam:
Are you currently going through menopause?	☐ Ye	es 🗌 No
If you have gone through menopause, how did	l it occur?	☐ Naturally ☐ Surgically
Have you had: Hysterectomy with remov	al of both o	ovaries Hysterectomy but both ovaries remain
Have you ever taken fertility drugs?		☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

Arimidex

☐ 3 or more years

☐ Tamoxifen

□ 1 – 2 years

Type_____Duration ____

Type_____Duration _____

Other _____

Have you ever taken birth control pills?

How long?

Have you ever taken anti-estrogen therapies?

Have you ever taken hormone replacement therapies?

Less than 1 year



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New Patient Ev	aluation				Pag	e 3 of 7					
Are you allergic to	latex?	☐ Yes [□No	Are	you allerg	c to surgi	cal tape?	☐ Ye	s 🗌 No		
Are you allergic to	any medi	cations?	☐ Ye	s 🗌 No	If yes , li	st the med	dication an	d the typ	e of allerç	gy/reaction	below:
Medication					Allergic	Reaction					
Pain Do you currently h	nave nain?	□ Yes	: □ No	Where	.?						
Do you take pain			∕es □ N								
If yes, does it con	trol your p	ain?	Yes [□ No □	Certair	nly 🗌 P	artially				
What other things	help contr	ol the pair	n (ex. ma	assage, he	eat, etc.)?						
Please rate (circle	e) the wors	t pain you	have ha	d in the la	ast 24 hou	rs (0 = nc	pain, 10 =	worst p	ain you h	ave ever h	ad):
0	1	2	3	4	5	6	7	8	9	10	
Personal and Socia	al History										
Place of Birth:									, , , , , , , , , , , , , , , , , , , ,		
Education (high sch	ool, college	e, etc.):									
Do you work outside	the home	? 🗆 Yes	□ No l	☐ Retire	d Type o	of work:					
are you currently?	Single	☐ Marrie	ed/Civil L	Jnion 🗆	Widowed	☐ Divor	ced \square D	omestic	Partner		
low many people liv	ve with you	ı in your h	ousehol	d?	# of	Children:		/	Ages: _		





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Review of Systems		
Do you currently have any problem	with anything mention	ned 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	





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Cancer Family History	
Have you ever been diagnosed with cancer? □ Yes □ No	
Have you or any of your relatives over had genetic testing? - Vee	- No

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

			Туре	e(s) of	Cancer			Age(s) at	t Diag	gnosis			Current	Age
You														
Immediate Family	y	Tot	al	Nu	mber	Type(s)	of C	ancer	Ag	e(s) at	Curre	nt	Age	at Death
		Num	ber	with	Cancer				Dia	agnosis	Age			
Your Daughter(s	5)													
Your Son(s)														
Your Brother(s)														
Your Sisters(s)														
Paternal Relatives		Type(s) of Cancer			Age(s) at Diagnosis	Current Age at Age Death				Ethi	nic Backgr	ound		
Your Father														
Your Father's Mother														
Your Father's Father														
	Total Num		Nun with Can		Type(s) of Cancer	Į.			Age(s)			Current Age	Age at Death
Your Father's Sister(s)														
Your Father's Brother(s)														
Your Paternal Cousins														





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New Patient Evaluation

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Maternal Relatives	1	Type(s) of Can	cer	Age(s) at	Current		ge at	Ethnic Backg	round
				Diagnosis	Age	D	eath		
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 Relation	onship	Type(s) of	Cancer	Age(s) at D	Diagnosis	Cı	urrent Age	Age	at Death
to you (i.e nie nephew, etc									
mments and /or fa	milv med	lical history ve	ou feel wo	uld be releva	nt·				
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<u>Current Medications</u> – If you have not brought your own list: Please list ALL PRESCRIPTION and NON-PRESCRIPTION drugs including vitamins, herbs, etc.

Name	Dose	Frequency
	_	