Lewis and Faye Manderson Cancer Center
at DCH Regional Medical Center

Patient Name: ______________________________
DOB: ________________ Date: _______________
M# _____________ Doctor: __________________

NEW PATIENT INFORMATION

Reason for Visit (Conditions or Symptoms): ____
____

(Please Mark One) New Patient: ___________ Follow-Up Doctor: ___________ Follow-Up Chemo: ___________
Primary Medical Doctor: __________________________ Specialist Doctor: ____________________________________
Preferred Pharmacy: ____

Please list any Medications:

DRUG NAME	DOSE	FREQUENCY (HOW OFTEN)

Please list any Allergies and Adverse Drug Reactions (food allergies, drug allergies):

ALLERGY	DESCRIBE REACTION

Do you have a sensitivity or allergy to Latex: YES ______ NO ______ If yes, please select or describe below

☐ Band Aids/Tape ☐ Balloons ☐ Kitchen/Rubber Gloves ☐ Condoms and Diaphragms
☐ Clothing with Elastic ☐ Other Rubber Products: ____

MEDICAL HISTORY (check all that apply):

☐ Cancer ☐ High Cholesterol ☐ Blood Clot ☐ High Blood Pressure ☐ Diabetic ☐ Psychiatric Disorders ☐ Dialysis
☐ Emphysema/Asthma ☐ Restless Leg Syndrome ☐ Heart Disease ☐ Stroke/CVA ☐ Home Oxygen Therapy

Please list other Medical History: ____
____
____
____
____

PROCEDURE/SURGERY HISTORY (mark all that apply) – List Date Performed and Doctor's Name:

☐ Appendix: ____________________ ☐ Back: ________________________ ☐ Biopsy: ____________________
☐ CABG (Heart): _________________ ☐ Cardiac Stents: _______________ ☐ Colonoscopy/EGD:_____________
☐ Colon Resection:_______________ ☐ C-Section: ___________________ ☐ Gallbladder: _________________
☐ Gastric Bypass: ________________ ☐ Hernia Repair:________________ ☐ Joint Replacement: ___________
☐ Hysterectomy: ________________ ☐ Mastectomy: ________________ ☐ Pacemaker: __________________
☐ Tubal Ligation: ________________ ☐ Tonsillectomy: _______________ ☐ Other Operations (specify below)

____
____

Revised 2/2020

GYNECOLOGIC (Female Only):

Pregnancies: # of Births: _________ # of Pregnancies: __________ Age at first Birth: ______________

Menstrual Cycle: Age Menstrual Cycle Started: _______ Last Cycle Date: _______ Cycle Length (days): ________

Menopause Status: ☐ Pre ☐ Peri ☐ Post ☐ Unknown ☐ No Answer Age of Menopause: ______________

Menopause Reason: ☐ Natural ☐ Chemo ☐ Removal of Ovaries ☐ Other

Hormone Use: ☐ Any Hormone Use ☐ Over the Counter Products/# of years used: _____________________

☐ Post Menopause Use/# of years used: __________ ☐ Other Hormone Use/# of years used: _____________

When was your last Pap Smear: ________________ **When was your last Mammogram**: __________________

FAMILY HISTORY (if unsure leave blank) – Please list any cancer history.

Mother

☐ Alive age: _______

☐ Deceased age: _______

Medical History: _____________________

____

Father

☐ Alive age: _______

☐ Deceased age: _______

Medical History: ______________________

____

Brother

☐ Alive age: _______

☐ Deceased age: _______

Medical History: _____________________

____

Brother

☐ Alive age: _______

☐ Deceased age: _______

Medical History: ______________________

____

Sister

☐ Alive age: _______

☐ Deceased age: _______

Medical History: _____________________

____

Sister

☐ Alive age: _______

☐ Deceased age: _______

Medical History: ______________________

____

Maternal Grandmother

☐ Alive age: _______

☐ Deceased age: _______

Medical History: _____________________

____

Paternal Grandmother

☐ Alive age: _______

☐ Deceased age: _______

Medical History: ______________________

____

Maternal Grandfather

☐ Alive age: _______

☐ Deceased age: _______

Medical History: _____________________

____

Paternal Grandfather

☐ Alive age: _______

☐ Deceased age: _______

Medical History: ______________________

____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ____

Smoking: ☐ Never ☐ Yes – Occasional ☐ Yes – But Quit ☐ Yes – Current/Active

years: ___________ # packs per day: ___________ Years Quit: ___________ Months Quit: ___________

Alcohol: ☐ Never ☐ Yes – Occasional ☐ Yes – But Quit ☐ Yes – Active ☐ Social - # drinks per year:__________

drinks per day: __________ # drinks per week: __________Years Quit: __________ Months Quit: __________

Products: ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Recreational Drug Use

☐ Other Petroleum Products ☐ Other: ____

Contact with Hazardous Materials: ☐ Contact ☐ No Contact ☐ Unknown

☐ Asbestos ☐ Benzene ☐ Lead ☐ Radiation

☐ Other Petroleum Products ☐ Other: ____

Support System:

Living Status: Do you live Locally? ☐ YES ☐ NO

☐ Lives with Spouse or Significant Other ☐ Lives Alone ☐ Lives with Family/Friend ☐ Incarcerated

☐ Lives in Own House ☐ Lives in a Nursing Home ☐ Lives in an Assisted Living Environment ☐ Homeless

Transportation/Support:

☐ Adequate Transportation Available for Expected Visits ☐ Transportation Problems Exist & requires assistance

☐ Supportive Family/Friends willing to assist with needs ☐ No Support System Exists to assist with needs

☐ Referred to Social Services for Assistance ☐ Has used a Home Health Care Agency ___________________

☐ Evidence of Abuse or Neglect ☐ No Abuse or Neglect Identified ☐ Other: ___________________________

Highest Level of Education Completed:

☐ Some High School ☐ High School/GED ☐ Technical/Occupational Certificate ☐ Associate Degree

☐ Some College Coursework ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate/Professional Degree

☐ Other (if not listed, please specify): ____

Activity:

☐ Sedentary ☐ Daily Activities ☐ Occasional Exercise ☐ Light Exercise ☐ Regular Exercise

☐ Extensive Exercise ☐ Other Exercise/Activity: ____

Check all that apply:

☐ History of Falling – Immediate or Within the Past 3 Months

☐ Use of Ambulatory Aid (please list type): ____

Nutrition (check all that apply):

☐ Regular Diet ☐ Diabetic Diet ☐ Liquid Diet ☐ Nutritional Supplements ☐ IV Nutrition

☐ Tube Feeding (please specify type): ______________________ ☐ Other: _______________________________

Do you have difficulty with: ☐ Chewing ☐ Swallowing ☐ Neither

Weight:

☐ Gain - Please list the amount gained over the past 6 months _______________

☐ Loss - Please list the amount lost over the past 6 months _________________

- Is your weight loss: ☐ Intentional ☐ Unintentional

Do you have an IV access line?

☐ YES (if please specify what type below) ☐ NO

☐ Groshong ☐ Picc Line ☐ Mediport

Do you have an Advance Directive?

☐ YES (if yes, please bring a copy for your chart) ☐ NO

Do you need additional information regarding an Advance Directive (Living Will)?

☐ YES ☐ NO

Do you need a referral to meet with a:

Chaplain?

☐ YES ☐ NO

Social Worker?

☐ YES ☐ NO

Financial Counselor?

☐ YES ☐ NO

Pain:

On the scale to the right, 0 being absence of pain and 10 being the worst pain imaginable. Circle the # that best represents your pain.	0 1 2 3 4 5 6 7 8 9 10 No Pain Worst Pain

Duration of Pain (in days, weeks, months, years): ____
Location of Pain: ____
Have you had any pain(s) in the recent past: ____
Present Pain Management and Effectiveness: ____
____

How does your pain effect/interfere with your activities of daily living:
☐Function ☐ Sleep ☐Appetite ☐Relationships ☐Emotions ☐Concentration
☐None ☐ Other (please specify): ______________________________

<u>PLEASE CIRCLE ANY OF THE PROBLEMS LISTED BELOW THAT YOU HAVE BEEN EXPERIENCING:</u>

GENERAL: No Complaint / Fever or Chills / Night Sweats / Weight Loss

EYES: No Complaint / Double Vision / Pain / Blurred Vision

EARS: No Complaint / Ringing / Pain / Discharge

NOSE: No Complaint / Post Nasal Drip / Discharge / Bleeding

THROAT: No Complaint / Pain / Coating

LUNGS: No Complaint / Cough / Sputum / Shortness of Breath / Pain with Breathing

HEART: No Complaint / Chest Pain / Shortness of Breath / Feet Swelling / Irregular Heart Beat

BLOOD: No Complaint / Bleeding / Bruising / Enlarged Lymph Node

NEUROLOGIC: No Complaint / Dizziness / Numbness / Weakness / Headache

ABDOMEN: No Complaint / Pain /Nausea or Vomiting / Diarrhea / Constipation / Dark or Bloody Stools

GYNECOLOGIC: No Complaint / Menstrual Changes / Pain or Cramping

GENITOURINARY: No Complaint / Pain / Difficulty Urinating / Blood in Urine

MUSCOLOSKELETAL: No Complaint / Pain / Stiffness / Decreased Movement / Weakness

SKIN: No Complaint / Bruising / Rash / Worrisome Growth / Itching

BREAST: No Complaint / Lactation (Breast Feeding) / Pain / Mass / Nipple Discharge

PSYCHIATRIC: No Complaint / Delusions / Hallucinations / Mood Swings / Depression / Suicidal Thoughts / Homicidal Thoughts

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Patient (or Responsible Party) Signature: ______________________________ Date: ______________

Nurse Signature: ____ Date: ______________