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)

_____
_____

Have you ever received:
Chemotherapy? ☐ Yes ☐ No If yes, where: _____
Radiation? ☐ Yes ☐ No If yes, where: _____

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) – Has anyone had any of the following: Cancer, Stroke, Heart Disease, Diabetes, Hypertension or other medical condition.

	AGE	AGE AT DEATH	MEDICAL HISTORY
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____

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): _____

PLEASE CIRCLE ANY OF THE PROBLEMS LISTED BELOW THAT YOU HAVE BEEN EXPERIENCING:

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

Patient (or Responsible Party) Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

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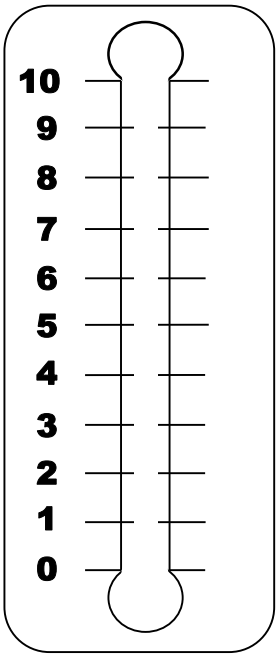
PATIENT LABEL

Spiritual and Psychosocial Distress Screening New Patient Form

Please circle the number (0-10) on the thermometer that most closely resembles how much distress you have experienced in the **past week,** including today.

Highly Distressed



Not Distressed

Please indicate if any of the following has been a concern for you in the **past week**, including today. Be sure to check either YES or NO for each.

YES/NO – Practical Concerns
- ☐ ☐ Child Care
- ☐ ☐ Housing
- ☐ ☐ Insurance/Financial
- ☐ ☐ Transportation
- ☐ ☐ Work/School
- ☐ ☐ Treatment Decisions
- ☐ ☐ Food

YES/NO – Emotional Concerns
- ☐ ☐ Depression
- ☐ ☐ Fears
- ☐ ☐ Nervousness
- ☐ ☐ Sadness
- ☐ ☐ Worry
- ☐ ☐ Loss of Interest in Usual Activities

YES/NO – Spiritual/Religions Concerns
- ☐ ☐ Questions about God
- ☐ ☐ Loss of Faith
- ☐ ☐ Loss of Hope
- ☐ ☐ Guilt
- ☐ ☐ Lack of Community
- ☐ ☐ Conflicts in Belief

YES/NO – Family Concerns
- ☐ ☐ Dealing with Children
- ☐ ☐ Dealing with Partner
- ☐ ☐ Ability to Have Children
- ☐ ☐ Family Health Issues

If you checked yes in any box, please explain: _____
_____
_____
_____
_____

There are support groups available through the Lewis and Faye Manderson Cancer Center. Please indicate if you are interested in participating in a support group. ☐ YES ☐ NO

FOR OFFICE USE ONLY: _____
_____
_____

☐ Pastoral Care ☐ Social Services ☐ Other _____

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