Advocate Health Care

New Patient Questionnaire

Thank you for taking a few minutes to complete this history form. It will help your new doctor focus on the problems that have brought you here for this appointment and allow more time for you to get your questions and concerns fully addressed.

Cancer Specialists treat many different diseases. We understand that not all the questions in this form will apply to you. Please try to answer all the questions to the best of your knowledge and write "N/A" for "not applicable" if you feel a particular question does not apply to you. We realize that this is an extensive questionnaire and we appreciate your time in completing it so that we are better able to address your questions.

Please answer as many questions as possible and ask your nurse or doctor if there are questions that you are unsure about.

Advocate Health Care

Date of Visit ___/___/___ **Date of Birth** ___/___/___

Patient Name _____ **MR #** _____

Address _____

Visit Information:	
Who is with you today?	
What is your diagnosis?	
When were you diagnosed?	At which hospital?
What physician referred you to our clinic?	
What is your understanding of why you are being seen today? Consultation ☐ 2nd Opinion ☐ Treatment/follow-up ☐	
Do you want to see or were you referred to a specific Oncologist? ☐ Yes ☐ No If yes, which Oncologist?	
Describe how your illness started, how it was diagnosed, and what has happened up to now:	

Physician Information: Please provide the names and contact information (office address, phone, fax, specialty, or hospital affiliation) for all of the doctors involved in your care.

Specialty	Physician Name Address/ Hospital Affiliation	Phone	Fax
Family M.D./ Primary Care/ Internist:			
Medical Oncologist:			
Radiation Oncologist:			
Surgeon:			
Gynecologist:			

Allergies: Include medications/food/environmental	☐ **No known allergies**
Allergy	**Describe reaction**

Medications: Include vitamins, herbal medications, hormones, over-the-counter and prescription medications. If details are unknown, please indicate "N/K" in the box.

Medication	Dose	How often	Who prescribed	Why you take it	Date started

Pain Scale

If you are currently having pain, please rate your pain by drawing a circle around the number on the scale that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (most severe pain)

Where is your pain located?		
How long have you had this pain?		
Are you taking medication for your pain? If yes, what medication(s)?	Yes ☐	No ☐
Does the medication help your pain?	Yes ☐	No ☐
*(**Office use only**):* Karnofsky Score _____%		

Past Medical History: (Please check all that apply)	Yes	No	Describe
Other cancers?	☐	☐	
Cardiovascular			
• High blood pressure	☐	☐	
• High cholesterol	☐	☐	
• Arrhythmia	☐	☐	
• Heart attack (MI)	☐	☐	Date (year): _____
• Congestive heart failure	☐	☐	
• Stroke/TIA	☐	☐	Date (year): _____
• Blood clots/Bleeding disorder	☐	☐	
Respiratory			
• Emphysema/COPD	☐	☐	
• Asthma	☐	☐	
Endocrine			
• Thyroid Disease	☐	☐	
• Diabetes	☐	☐	
Gastrointestinal			
• Reflux	☐	☐	
• Stomach ulcer	☐	☐	
• Liver disease/cirrhosis/hepatitis	☐	☐	
• Irritable Bowel/Crohn's/Colitis	☐	☐	
• Bowel Disease (polyps)	☐	☐	
• Other stomach problems	☐	☐	
Genitourinary			
• Kidney or bladder problems	☐	☐	
• Gynecological problems/HPV	☐	☐	
• Prostate problems/BPH/prostatitis	☐	☐	
• Sexual dysfunction	☐	☐	
Musculoskeletal			
• Arthritis	☐	☐	
• Osteoporosis	☐	☐	
Autoimmune			
• Rheumatoid Arthritis/Lupus	☐	☐	
• HIV/AIDS	☐	☐	
Neurologic			
• Epilepsy/seizure disorder	☐	☐	
• Parkinson's/Alzheimer's	☐	☐	
• Depression/anxiety	☐	☐	
• Bipolar/Schizophrenia/Panic Disorder	☐	☐	
Other diseases?	☐	☐	

History of Surgery or other Procedures		☐ No prior surgeries/ procedures
Date of surgery/procedure	**Type of surgery/procedure**	**Hospital/clinic where performed**

Do you have an Internal Electronic Device, i.e. defibrillator, pacemaker? Yes ☐ No ☐
If yes, please have your card ready at the time of consultation for the nurse and doctor.

History of Radiation or Chemotherapy		☐ No previous cancer treatment
Date	**Type of Treatment**	**Hospital/clinic where performed**

Social History
Where were you born? (state or country)
What is your race/ ethnicity?
What type of work did/do you do: Retired ☐
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
With whom do you live?
Do you have children? Yes ☐ No ☐ List ages:
Do you drink alcohol? Yes ☐ No ☐ Number of drinks per week: If you used to drink, when did you stop?
Do you use tobacco products now or in the past? (cigars, cigarettes, tobacco) Yes ☐ No ☐ Number of years: _____ Number of packs per day: _____ When did you quit? _____ Are you interested in information regarding smoking cessation? Yes ☐ No ☐
Do you use recreational drugs? Yes ☐ No ☐ What drug(s)? How often?
Do you have special religious, spiritual, or cultural needs we need to be aware of: Yes☐ No ☐ If yes, please explain:
Do you have Advanced Directives (living will, power of attorney for health care)? Yes ☐ No ☐ If yes, could you provide a copy for your records? Yes ☐ No ☐ Would you like more information about obtaining Advanced Directives? Yes ☐ No ☐
(***Office use only***): If yes, referral made to:

Family History: Please list any cancer or blood disease your family members have had. If you do not know exact ages, please estimate.					
Family member	**Current age**	**Age at diagnosis**	**Age at death**	**Type of cancer/ blood disease**	
Yourself					
Your siblings (Please circle either sister or brother)					
Sister Brother					
Sister Brother					
Sister Brother					
Sister Brother					
Sister Brother					
Your children (Please circle either daughter or son)					
Daughter Son					
Daughter Son					
Daughter Son					
Daughter Son					
Daughter Son					
Your Father's Family (Please circle either Aunt or Uncle)					
Father					
Paternal Grandfather					
Paternal Grandmother					
Aunt Uncle					
Aunt Uncle					
Aunt Uncle					
Aunt Uncle					
Other					
Other					
Other					
Your Mother's Family (Please circle either Aunt or Uncle)					
Mother					
Maternal Grandfather					
Maternal Grandmother					
Aunt Uncle					
Aunt Uncle					
Aunt Uncle					
Aunt Uncle					
Other					
Other					
Other					

Gynecological/Obstetric History – Women Only	Yes	No	
Age that you started menstruating:			Date of last menstrual period:
Are your periods regular?	☐	☐	
Have you had a hysterectomy?	☐	☐	Date:
Were your ovaries removed?	☐	☐	Date:
Have you gone through menopause?	☐	☐	How old were you?
Do/did you use oral contraceptives?	☐	☐	How long? When stopped:
Do/did you use hormone replacement therapy?	☐	☐	How long? When stopped:
Have you had gynecological or breast changes?	☐	☐	Explain:
Number of pregnancies: Number of live births:			Age at first full term pregnancy:
Could you be pregnant at this time?	☐	☐	
What is your bra and cup size? *(breast cancer patients only)*			

Health Maintenance		
Men and Women		
Have you had a sigmoidoscopy or colonoscopy?	☐ Yes, Date _____	☐ No
Has your doctor checked your stool for blood?	☐ Yes, Date _____	☐ No
Have you had your skin checked?	☐ Yes, Date _____	☐ No
Have you had an oral/dental exam?	☐ Yes, Date _____	☐ No
Have you had a flu vaccination?	☐ Yes, Date _____	☐ No
Have you had a pneumonia vaccination?	☐ Yes, Date _____	☐ No
Women only:		
Do you have regular mammograms?	☐ Yes, Date _____	☐ No
Do you have regular PAP tests?	☐ Yes, Date _____	☐ No
Do you examine your breasts regularly?	☐ Yes, Date _____	☐ No
Have you had a bone density (DEXA) scan?	☐ Yes, Date _____	☐ No
Men only:		
Do you examine your own testicles?	☐ Yes, Date _____	☐ No
Do you have regular prostate exams?	☐ Yes, Date _____	☐ No
Do you have regular PSA tests?	☐ Yes, Date _____	☐ No

Review of Systems: (Please circle all that apply)	Describe
General: weight loss, weight gain, always tired, weak, night sweats, fevers, chills	☐ No Problem
Skin: rash, change in moles, sores, lumps, itching, or hives	☐ No Problem
Eyes: pain in eyes, watery eyes, dry eyes, blurred vision, double vision, or other change in vision	☐ No Problem
Ears/nose/throat: hearing loss, ringing in the ears, stuffy nose or congestion, frequent sinus infections or sinus pain, change in taste or smell, soreness in mouth or throat, hoarseness, swollen glands, dental problems, dentures or partials	☐ No Problem
Respiratory: dry cough, productive cough, shortness of breath with exertion, wheezing, coughing up blood, home oxygen (____L/min)	☐ No Problem
Heart: chest pain, palpitations, pounding heart, swelling in legs/feet	☐ No Problem
Endocrine: excessive thirst, urination, or appetite, heat or cold intolerance, hot flashes	☐ No Problem
GI: abdominal pain, nausea, vomiting, heartburn or reflux, difficulty swallowing, diet restrictions, anorexia, constipation, diarrhea, change in bowel habits or incontinence, bright red blood in stools or dark tarry stools	☐ No Problem
GU: frequent urination, urgency with urination, difficulty starting stream or weak stream, pain or burning with urination, blood in urine, waking at night to urinate, urinary incontinence, vaginal bleeding, prostate problems or impotence	☐ No Problem
Blood/Lymphatic: anemia**,** easy bruising or bleeding, lymphedema or swelling, vascular access device (port/pic)	☐ No Problem
Infectious Disease: frequent infections or recent exposure to infectious disease	☐ No Problem
Extremities: Joint pain or swelling, muscle or bone pain, difficulty moving arms or legs, pain with walking	☐ No Problem
Neurologic: headaches, fainting, dizzy spells or vertigo, numbness or tingling, poor balance, memory loss, forgetfulness, confusion, changes in mood, focal weakness, paralysis, depression, anxiety or seizures	☐ No Problem
Do you have a recent history of falls? **Assistive devices you use:** ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches	Describe how fall occurred: ☐ No Falls

Family or Caregiver Contact Information

Due to the privacy regulations, we are unable to discuss your medical information without your permission. If you would like us to discuss your care with a significant other or family member, please provide the name, your relationship (spouse, son, daughter, friend), and a phone number for your contact person.

Contact: _____ Relationship: _____ Phone: _____

Personal Contact Information

The clinic staff have permission to leave messages on answering machines or voice mails regarding possible future appointments at the following numbers:

☐ Home _____
Area Code Number

☐ Cell _____
Area Code Number

☐ Work _____
Area Code Number

Best time for staff to phone: ☐ Mornings ☐ Afternoons

Pharmacy Information

The clinic staff have permission to electronically prescribe my prescriptions and may request my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

My preferred pharmacy:

Name: _____

Address: _____

Please inform our clinic if your preferred pharmacy information changes.

THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.

Patient Signature: _____ **Date**:_____

RN Signature: _____ **Date**:_____

Physician Signature: _____ **Date**:_____

Interpreter Signature (if applicable): _____ **Date**:_____

Office Use Only			
HT: _____ stated/measured	**WT:**_____ stated/measured	Oxygen Saturation: _____ %	
T : _____	**HR:** _____	**R:** _____	**BP:** _____
Lymphedema Assessment: □ NA			
Lt lower arm: _____	Lt upper arm: _____	Rt lower arm: _____	Rt upper arm: _____
Patient Referred to Genetics: □ NA	Date:	Initials:	
Physician Drawings/Diagrams			