New Patient History Questionnaire

Name:____

Primary Language:______________________________ Need Interpreter: ☐YES ☐ NO

Date of Birth: ______________ Gender: ______________ Ethnicity (Optional): ______________

Preferred Phone:______________________ Secondary Phone:______________________

E-mail:______________________________ Preferred Contact: ☐Call ☐ Text ☐E-mail

I consent to and understand the risks of receiving protected health information via e-mail: ☐ YES ☐ NO

Address:____

Emergency Contact Name:____

Primary Phone:______________________ Relation to you:______________________

MEDICAL TEAM

Referring Provider:______________________ Medical Oncologist:______________________

Surgeon:______________________ Primary Care:______________________

Dentist (Head & Neck only):______________________ Pharmacy:______________________

MEDICAL HISTORY

Current Diagnosis:____

Prior History of Cancer: ☐ YES ☐ NO Prior Diagnosis: ______________________

Prior to today, have you had any of the following outside of our facility?

Radiation: ☐ YES ☐ NO Start Date:__________ End Date:__________ Location:__________

Chemotherapy: ☐ YES ☐ NO Start Date:__________ End Date:__________ Location:__________

Do you have any implanted medical devices: ☐ Pacemaker/Defibrillator ☐ Pain Pump ☐Stent ☐ NONE

When was your last colonoscopy? Date:__________ Physician:______________ ☐ Never had one

Do you have Lupus or Scleroderma? ☐ YES ☐ NO

Answer if applicable:

Do you still want to have children? ☐ YES ☐ NO

Are you pregnant or think you may be pregnant? ☐ YES ☐ NO

MEDICATION OR LATEX ALLERGIES (use additional space if needed)

Do you have a known allergy to IV Contrast: ☐ YES ☐ NO If yes, Reaction?______________

Allergy	Allergic Reaction	Date of Last Reaction

Name:____

CURRENT SYMPTOMS – In the last 30 days have you had any of the following (check all that apply)

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Headaches
- ☐ Hoarseness
- ☐ Ear Pain/Ringing
- ☐ Numbness
- ☐ Cough
- ☐ Nausea
- ☐ Diarrhea
- ☐ Urinary frequency
- ☐ Bloody Stools
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Difficulty Swallowing
- ☐ Swollen Lymph Nodes
- ☐ Leg Swelling
- ☐ Muscle Weakness
- ☐ Visual Changes
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heartburn
- ☐ Seizures
- ☐ Hemorrhoids

FAMILY CANCER HISTORY (use additional space if needed)

Relative / Relation to You	Cancer Type	Age of Diagnosis

SURGERIES OR RECENT HOSPITALIZATIONS (use additional space if needed)

Type/Reason	Location/Facility	Date/Length

PAST MEDICAL HISTORY – Check All That Apply

Cognitive/Brain
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Alzheimer's/Dementia

Lung/Respiratory
- ☐ Asthma
- ☐ Pneumonia
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Pulmonary Fibrosis

Heart/Cardiac
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure

Muscular/Skeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ History of Bone Fractures
- ☐ Fibromyalgia

Stomach/Intestinal/Digestive
- ☐ Diabetes Type: ___________
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Acid Reflux/GERD
- ☐ Constipation
- ☐ Diarrhea

Blood/Hepatic/Circulation
- ☐ Liver Disease
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Hemochromatosis
- ☐ Gall Bladder Disease/Stones
- ☐ Hepatitis Type: ___________
- ☐ Jaundice

Bladder/Kidney/Urologic
- ☐ Kidney Stones
- ☐ Bladder Stones
- ☐ Kidney Disease

Additional Diseases
- ☐ Ehlers-Danlos Syndrome

List any others

____

____

Name:____

PAIN MANAGEMENT

Are you currently in pain? ☐ YES ☐ NO (if no, skip to next section)

On a scale of 0 – 10, what is your **average pain** level? __________

Over the last 7 days has your pain stopped you from doing daily tasks? ☐ YES ☐ NO

Do you currently see a Palliative Care Provider or Pain Specialist? ☐ YES ☐ NO

GYNECOLOGIC HISTORY (females only)

Age of Menarche: ______ Last Menstrual Period: ________ Age of Menopause if applicable: _________

History of Hormone Replacement Therapy? ☐ YES ☐ NO If yes, for how long? ____________________

CURRENT MEDICATIONS (If you need more space, provide current list of medications at your first visit)

Name of Medication	Dosage/Frequency	Prescriber

MENTAL HEALTH HISTORY

Do you have any of the following diagnosis? ☐Depression ☐Anxiety ☐OCD ☐Substance Use Disorder

Do you see a Mental Health Provider? ☐ YES ☐ NO

If no, are you interested in connecting with one? ☐ YES ☐ NO

SUBSTANCE USE HISTORY

Do you currently smoke cigarettes? ☐ YES ☐ NO Packs per day? ______ Age Started? ______

If no, did you smoke in the past? ☐ YES ☐ NO If yes, age you stopped? _________________

Do you use cannabis? ☐ YES ☐ NO If yes, frequency: _______________________

Do you currently drink alcohol? ☐ YES ☐ NO If yes, do you drink daily? ☐ YES ☐ NO

If you no longer consume alcohol, what age did you stop? _______________

Are you concerned about your substance use or alcohol use? ☐ YES ☐ NO

SOCIAL HISTORY

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

Living Accommodations: ☐ Own Home ☐ Rent ☐ Unhoused ☐ ALF ☐ Other:___________________

Lives with: ☐ Alone ☐ Spouse ☐ Minor Children ☐ Adult Children ☐ Family ☐ Roommates

Are you a Veteran? ☐ YES ☐ NO Service Connection/Disability %: ____________

Employment Status: ☐Employed ☐Unemployed ☐ Retired ☐ On Leave ☐On Disability

Do you have any of the following concerns? ☐Employment ☐Transportation ☐Finances ☐Insurance

Do you have an Oncology Navigator supporting you? ☐ YES ☐ NO Name:_________________________