Document Type: Forms/Other

MSC077

METHODIST HOSPITAL

ONCOLOGY NEW PATIENT INTAKE FORM

Please answer all questions to the best of your ability.

Patient Name: _____ Date of Birth: _____

Phone: (home)_____ (cell)_____

Email address: _____

Who referred you: _____ Why:_____

When did symptoms begin? _____ Are symptoms: Improving Staying the Same Worsening

Have you received any previous treatment?_____

Primary Care MD: _____

Other physicians currently participating in your care: _____

_____

Do you have an advance directive/living will/power of attorney? ☐ Yes ☐ No

Have you fallen within in the last 30 days? ☐ Yes ☐ No

Have you felt down, depressed or hopeless in the last 30 days? ☐ Yes ☐ No

SOCIAL HISTORY: Please circle the appropriate answer

Marital Status? Single Married Divorced Widowed

Do you use tobacco products? Never Current Former **# of packs/day**___ **Age**: started_____ quit_____

Do you drink alcohol? Never Current Former **Type:** Beer Wine Liquor **How often:** _____

Do you use recreational drugs? Never Current Former **Type:** _____ **Frequency:** _____

Employment: Working Retired Disabled **Type of work:**_____

Are you sexually active? Yes No

Do you currently participate in any exercise activity? Yes No

Home environment: Live alone _____ Live with _____

What type of diet do you currently follow: Regular Soft Liquid Diabetic Unable to eat

ALLERGIES: Please list out any allergies to medications, food, or environment. Include side effects if known.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

MEDICAL PROBLEMS: Example – asthma, cancer, diabetes, heart disease, high blood pressure.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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PAST SURGERIES: List any prior surgeries/procedures with date/year if known.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

FAMILY HISTORY: Please indicate Y for Yes and N for No

Does any member of your family (immediate blood relative) have a history of/currently suffer from any of the following?:

	Y	N	Relative		Y	N	Relative
Breast Cancer	_____	_____	_____	Thyroid Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____	Esophageal Cancer	_____	_____	_____
Lung Cancer	_____	_____	_____	Stomach Cancer	_____	_____	_____
Pancreatic Cancer	_____	_____	_____	Liver Cancer	_____	_____	_____
Melanoma	_____	_____	_____	Sarcoma	_____	_____	_____
Other Cancer(s)	_____	_____	_____				

List other cancer(s):_____

Asthma	_____	_____	_____	Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____	High Blood Pressure	_____	_____	_____
Other Condition(s)	_____	_____	_____				

List other condition(s):_____

Unknown_____ Adopted_____

REVIEW OF SYSTEMS

Please indicate if you have experienced any of the following symptoms recently: **Circle** any that apply

GENERAL:	Fevers, chills, weight loss, fatigue, loss of appetite
EYES, EARS, NOSE & THROAT:	Visual changes, double vision, ringing in ears, bleeding, ear/sinus infections
SKIN:	Rashes, changing moles, dryness, itching, sunburn
ENDOCRINE:	Intolerance to heat/cold, excessive thirst/hunger/urination
LUNGS:	Shortness of breath, cough, wheezing, blood in sputum
HEART:	Chest pain, irregular heartbeat, palpitations, chest pressure
GASTROINTESTINAL:	Abdominal pain, trouble swallowing, nausea, vomiting, diarrhea, constipation
GENITOURINARY:	Painful urination, blood in urine, frequent urination, incontinence
MUSCULOSKELETAL:	Muscle aches, back pain, joint pain, joint swelling
NEUROLOGICAL:	Headaches, numbness, weakness, memory loss, seizures, dizziness
PSYCHIATRIC:	Depression, anxiety, insomnia, mood changes
OTHER SYMPTOMS:	_____

Any additional things you would like your physician to know: _____

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

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