Document Type: Forms/Other

MSC077

SURGICAL ONCOLOGY
MIDWEST GYN/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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