

Patient Intake Form

Answers to the following questions will be helpful in managing your medical problems. Please feel free to provide additional details or discuss the answer to any of these questions with your treating physician.

Last Name	First Name	Middle	Today's date
Address	City	State	Zip Code
Preferred phone Number: May we leave a message Y / N	Other numbers: Home Cell work	Date of birth	Age
Emergency Contact/Relationship	Phone number		

Other physicians involved in your care:

Involved Physician	Address/Fax number If not based at Elmhurst	Phone Number If not based at Elmhurst
Primary physician		
Referring physician		
Medical oncologist		
Radiation oncologist		
Surgeon		
Other		

Page Two:

Please list any prior medical problems:

Please list prior surgeries with approximate dates:

Please describe any prior treatment with radiation:

Please describe any prior treatment with chemotherapy:

Pharmacy name and phone number _____

Please list all medications (prescription, over the counter, and herbal):

Do you have any **allergies** to any medications?

Page Three:

Does anyone in your family have cancer or another significant medical problem?

	Age	Medical Problem	Cause of death if deceased
Father:			
Mother:			
Siblings:			
Grandparents			
Other:			

Social History:

Do you/did you use tobacco?

Cigarettes: packs per day _____

Other tobacco: describe type/use _____

If you quit, then when? _____

How many years did you smoke? _____

Do you/did you drink alcohol?

Average number of drinks per week _____

If you quit, then when? _____

Do you/did you use recreational drugs? _____

Describe type and use _____

Birthplace _____

Relationship/marital status _____

Occupation/previous job _____

Name of spouse/significant other _____

Who currently lives with you?

Do you have a living will? Y / N

Designated Power of Attorney Y / N

Name/number

Any other concerns or anything you want your doctor to know about you?

Page Four:

Do you currently have or have you had any of the following illnesses/complaints?

	Yes	No	Details
General			
Weight change			
Fatigue			
Weakness			
Fevers/chills/night sweats			
Hot Flashes			
Pain			
Enlarged lymph nodes			
Head and Neck			
vision changes			
hearing loss			
Sore throat/difficulty swallowing			
Voice changes			
Skin			
Sores/ulcers			
Respiratory			
On oxygen			
Shortness of breath/trouble breathing			
Asthma/bronchitis/emphysema			
Coughing up blood			
Cardiac/vascular			
Hypertension/high blood pressure			
Heart murmur			
Chest pain/angina			
Heart attack			
Swelling/edema in feet/ankles/hands			
Gastrointestinal			
Nausea/vomiting			
Black/bloody stool			
Abdominal pain			
Hepatitis/liver disorder			
Ulcer			
Diarrhea			
Constipation			
Incontinence of stool			
Renal/Genitourinary			
Kidney disease			
Blood in urine			
Bladder infection			
Sexually transmitted disease			
Incontinence of urine			
Frequent urination			

Page Five:

	Yes	No	Details
Hematologic			
Anemia/transfusions			
Blood clots			
Musculoskeletal			
Weakness			
Arthritis			
Neurologic			
Headache			
Seizures			
Visual changes			
Hearing problems/changes			
Memory changes			
Dizziness/vertigo			
Numbness/tingling			
Stroke			
Psychiatric			
Depression			
Mental Illness			
Other			
Immune disorder			
Lupus/other autoimmune disorder			
Diabetes			
Other (please describe)			
Other (please describe)			

Are you having any pain? Y / N
Where?

On a scale of 0 to 10 score your pain:
0 --- 5 --- 10
No moderate worst possible
pain pain pain

For women only:

How many times have you been pregnant? _____ How many children do you have? _____

Age at first child birth? _____

Age at first menstrual period? _____ Age at menopause? _____

Are you using/did you use hormone replacement therapy? _____

Are you sexually active? _____

Are you using birth control? _____
Which type? _____

Could you be pregnant? _____

For men only:

Are you currently trying to have children?