

Lewis and Faye Manderson Cancer Center

at DCH Regional Medical Center



Patient Name: _____

DOB: _____ Date: _____

M# _____ Doctor: _____

NEW PATIENT INFORMATION

Reason for Visit (Conditions or Symptoms): _____

(Please Mark One) New Patient: _____ Follow-Up Doctor: _____ Follow-Up Chemo: _____

Primary Medical Doctor: _____ Specialist Doctor: _____

Preferred Pharmacy: _____

Please list any Medications:

DRUG NAME	DOSE	FREQUENCY (HOW OFTEN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any Allergies and Adverse Drug Reactions (food allergies, drug allergies):

ALLERGY	DESCRIBE REACTION
_____	_____
_____	_____
_____	_____

Do you have a sensitivity or allergy to Latex: YES _____ NO _____ If yes, please select or describe below

- Band Aids/Tape
 Balloons
 Kitchen/Rubber Gloves
 Condoms and Diaphragms
 Clothing with Elastic
 Other Rubber Products: _____

MEDICAL HISTORY (check all that apply):

- Cancer
 High Cholesterol
 Blood Clot
 High Blood Pressure
 Diabetic
 Psychiatric Disorders
 Dialysis
 Emphysema/Asthma
 Restless Leg Syndrome
 Heart Disease
 Stroke/CVA
 Home Oxygen Therapy

Please list other Medical History: _____

PROCEDURE/SURGERY HISTORY (mark all that apply) – List Date Performed and Doctor’s Name:

- | | | |
|---|--|---|
| <input type="checkbox"/> Appendix: _____ | <input type="checkbox"/> Back: _____ | <input type="checkbox"/> Biopsy: _____ |
| <input type="checkbox"/> CABG (Heart): _____ | <input type="checkbox"/> Cardiac Stents: _____ | <input type="checkbox"/> Colonoscopy/EGD: _____ |
| <input type="checkbox"/> Colon Resection: _____ | <input type="checkbox"/> C-Section: _____ | <input type="checkbox"/> Gallbladder: _____ |
| <input type="checkbox"/> Gastric Bypass: _____ | <input type="checkbox"/> Hernia Repair: _____ | <input type="checkbox"/> Joint Replacement: _____ |
| <input type="checkbox"/> Hysterectomy: _____ | <input type="checkbox"/> Mastectomy: _____ | <input type="checkbox"/> Pacemaker: _____ |
| <input type="checkbox"/> Tubal Ligation: _____ | <input type="checkbox"/> Tonsillectomy: _____ | <input type="checkbox"/> Other Operations (specify below) _____ |

Have you ever received:

Chemotherapy? Yes No If yes, where: _____

Radiation? Yes No If yes, where: _____

GYNECOLOGIC (Female Only):

Pregnancies: # of Births: _____ # of Pregnancies: _____ Age at first Birth: _____
Menstrual Cycle: Age Menstrual Cycle Started: _____ Last Cycle Date: _____ Cycle Length (days): _____
Menopause Status: Pre Peri Post Unknown No Answer Age of Menopause: _____
 Menopause Reason: Natural Chemo Removal of Ovaries Other
Hormone Use: Any Hormone Use Over the Counter Products/# of years used: _____
 Post Menopause Use/# of years used: _____ Other Hormone Use/# of years used: _____
When was your last Pap Smear: _____ **When was your last Mammogram:** _____

FAMILY HISTORY (if unsure leave blank) – Has anyone had any of the following: Cancer, Stroke, Heart Disease, Diabetes, Hypertension or other medical condition.

	AGE	AGE AT DEATH	MEDICAL HISTORY
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Brother/Sister (circle one)	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Maternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____
Paternal Aunt/Uncle (circle one)	_____	_____	_____

Marital Status: Single Married Separated Divorced Widowed

Occupation: _____

Smoking: Never Yes – Occasional Yes – But Quit Yes – Current/Active
 # years: _____ # packs per day: _____ Years Quit: _____ Months Quit: _____

Alcohol: Never Yes – Occasional Yes – But Quit Yes – Active Social - # drinks per year: _____
 # drinks per day: _____ # drinks per week: _____ Years Quit: _____ Months Quit: _____

Products: Cigarettes Cigars Chewing Tobacco Pipe Recreational Drug Use
 Other Petroleum Products Other: _____

Contact with Hazardous Materials: Contact No Contact Unknown
 Asbestos Benzene Lead Radiation
 Other Petroleum Products Other: _____

Support System:

Living Status: Do you live Locally? YES NO

- Lives with Spouse or Significant Other Lives Alone Lives with Family/Friend Incarcerated
 - Lives in Own House Lives in a Nursing Home Lives in an Assisted Living Environment Homeless
- Transportation/Support:

- Adequate Transportation Available for Expected Visits Transportation Problems Exist & requires assistance
- Supportive Family/Friends willing to assist with needs No Support System Exists to assist with needs
- Referred to Social Services for Assistance Has used a Home Health Care Agency _____
- Evidence of Abuse or Neglect No Abuse or Neglect Identified Other: _____

Highest Level of Education Completed:

- Some High School High School/GED Technical/Occupational Certificate Associate Degree
- Some College Coursework Bachelor’s Degree Master’s Degree Doctorate/Professional Degree
- Other (if not listed, please specify): _____

Activity:

- Sedentary Daily Activities Occasional Exercise Light Exercise Regular Exercise
- Extensive Exercise Other Exercise/Activity: _____

Check all that apply:

- History of Falling – Immediate or Within the Past 3 Months
- Use of Ambulatory Aid (please list type): _____

Nutrition (check all that apply):

- Regular Diet Diabetic Diet Liquid Diet Nutritional Supplements IV Nutrition
- Tube Feeding (please specify type): _____ Other: _____

Do you have difficulty with: Chewing Swallowing Neither

Weight:

- Gain - Please list the amount gained over the past 6 months _____
- Loss - Please list the amount lost over the past 6 months _____
 - Is your weight loss: Intentional Unintentional

Do you have an IV access line?

- YES (if please specify what type below) NO
- Groshong Picc Line Mediport

Do you have an Advance Directive?

- YES (if yes, please bring a copy for your chart) NO

Do you need additional information regarding an Advance Directive (Living Will)?

- YES NO

Do you need a referral to meet with a:

Chaplain?

- YES NO

Social Worker?

- YES NO

Financial Counselor?

- YES NO

Pain:

On the scale to the right, 0 being absence of pain and 10 being the worst pain imaginable. Circle the # that best represents your pain.	0	1	2	3	4	5	6	7	8	9	10
	No Pain						Worst Pain				

Duration of Pain (in days, weeks, months, years): _____

Location of Pain: _____

Have you had any pain(s) in the recent past: _____

Present Pain Management and Effectiveness: _____

How does your pain effect/interfere with your activities of daily living:

- Function Sleep Appetite Relationships Emotions Concentration
 None Other (please specify): _____

PLEASE CIRCLE ANY OF THE PROBLEMS LISTED BELOW THAT YOU HAVE BEEN EXPERIENCING:

GENERAL: No Complaint / Fever or Chills / Night Sweats / Weight Loss

EYES: No Complaint / Double Vision / Pain / Blurred Vision

EARS: No Complaint / Ringing / Pain / Discharge

NOSE: No Complaint / Post Nasal Drip / Discharge / Bleeding

THROAT: No Complaint / Pain / Coating

LUNGS: No Complaint / Cough / Sputum / Shortness of Breath / Pain with Breathing

HEART: No Complaint / Chest Pain / Shortness of Breath / Feet Swelling / Irregular Heart Beat

BLOOD: No Complaint / Bleeding / Bruising / Enlarged Lymph Node

NEUROLOGIC: No Complaint / Dizziness / Numbness / Weakness / Headache

ABDOMEN: No Complaint / Pain /Nausea or Vomiting / Diarrhea / Constipation / Dark or Bloody Stools

GYNECOLOGIC: No Complaint / Menstrual Changes / Pain or Cramping

GENITOURINARY: No Complaint / Pain / Difficulty Urinating / Blood in Urine

MUSCOLOSKELETAL: No Complaint / Pain / Stiffness / Decreased Movement / Weakness

SKIN: No Complaint / Bruising / Rash / Worrisome Growth / Itching

BREAST: No Complaint / Lactation (Breast Feeding) / Pain / Mass / Nipple Discharge

PSYCHIATRIC: No Complaint / Delusions / Hallucinations / Mood Swings / Depression / Suicidal Thoughts / Homicidal Thoughts

Patient (or Responsible Party) Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

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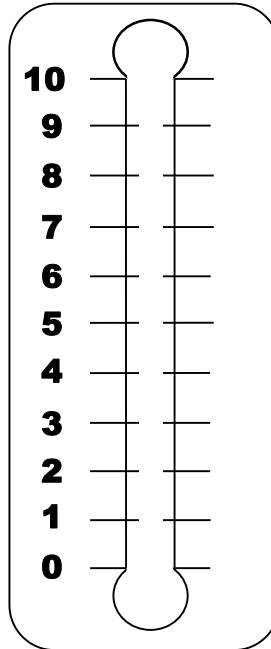


PATIENT LABEL

Spiritual and Psychosocial Distress Screening New Patient Form

Please circle the number (0-10) on the thermometer that most closely resembles how much distress you have experienced in the **past week**, including today.

Highly Distressed



Not Distressed

Please indicate if any of the following has been a concern for you in the **past week**, including today. Be sure to check either YES or NO for each.

YES/NO – Practical Concerns

- Child Care
- Housing
- Insurance/Financial
- Transportation
- Work/School
- Treatment Decisions
- Food

YES/NO – Emotional Concerns

- Depression
- Fears
- Nervousness
- Sadness
- Worry
- Loss of Interest in Usual Activities

YES/NO – Spiritual/Religions Concerns

- Questions about God
- Loss of Faith
- Loss of Hope
- Guilt
- Lack of Community
- Conflicts in Belief

YES/NO – Family Concerns

- Dealing with Children
- Dealing with Partner
- Ability to Have Children
- Family Health Issues

If you checked yes in any box, please explain: _____

There are support groups available through the Lewis and Faye Manderson Cancer Center. Please indicate if you are interested in participating in a support group. YES NO

FOR OFFICE USE ONLY: _____

 Pastoral Care Social Services Other _____