ALLIANCE
Cancer Specialists

New Patient Evaluation

Dear New Patient, **Date:_____**

Welcome to our practice. Please fill out the information to the best of your ability.

Name:_____ Date of Birth:_____ Sex: M / F

Diagnosis/Reason for your visit :_____

Referring Physician:_____ Family Physician:_____

Please list all other Physicians that you would like to have a copy of your medical information:

_____

_____

Pharmacy you typically use(name,city,state,phone):_____

Preferred Language:_____ Race: _____ Ethnicity: _____

CURRENT MEDICATIONS (Including over the counter, dose and frequency):

1.)_____ 5.)_____

2.)_____ 6.)_____

3.)_____ 7.)_____

4.)_____ 8.)_____

ALLERGIES (Including adverse reaction if known):_____

_____

SOCIAL HISTORY

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Occupation_____ Retired? Yes / No

Exposure to Hazardous Materials? Yes / No ( )Asbestos ( ) Benzene ( ) Lead ( ) Radiation Other _____

Alcohol Use: ( ) Never ( ) Rare ( ) Moderate ( ) Daily #_____ drinks per day / week

Tobacco Use: ( ) Never ( ) Quit ____months / years ( ) Current Smoker #_____ packs per day #_____year(s)

( ) Cigarettes ( ) Cigars ( ) Chewing Tobacco ( ) Pipe ( ) Recreational Drug Use _____

Please indicate your activity level: ( ) Sedentary ( ) Daily Activities ( ) Exercise Occasional / Regular / Extensive

Name:_____

PAST MEDICAL HISTORY

( )Aids or HIV+
( )Alcoholism
( )Alzheimers
( )Anemia
( )Anorexia
( )Anxiety
( )Arteriovenous Malormations
( )Asthma
( )Atrial Fibrillation
( )Autoimmune Disease
( )Benign Prostatic Hypertrophy
( )Bleeding/Clotting Disorder
( )Blood Pressure High / Low
( )Cancer Type:_____
( )Cataracts
( )Chrons Disease
( )COPD
( )Congenital Heart Defects
( )Congestive Heart Failure
( )Coronary Artery Disease
( )Depression
( )Diabetes Type 1 / 2
( )Diverticulitis
( )Diverticulosis
( )Drug Dependency
( )Elevated Cholesterol
( )Endocarditis
( )Endometriosis
( )Fibromyalgia
( )Gallstones
( )GERD
( )Gout
( )Hearing Loss
( )Hemochromatosis
( )Hepatitis A / B / C
( )Hyperlipidemia
( )Hypertension
( )Hyperthyroidism
( )Hypotension
( )Hypothyroidism
( )Irritable Bowel Syndrome
( )Kidney Stones
( )Manic Depressive Disorder
( )Migraines
( )Mitral Valve Prolapse
( )Myocardial Infarction
( )Obesity
( )Osteoarthritis
( )Osteopenia
( )Osteoporosis
( )Pancreatitis
( )Peripheral Neuropathy
( )Peripheral Vascular Disease
( )Rheumatoid Arthritis
( )Seizure
( )Stroke
( )Thalassemia
( )Thrombocytopenia
( )Thrombocytosis
( )TIA
( )Tuberculosis
( )Ulcers
( )Vertigo
( )Vision Loss
( )_____
( )_____

PAST SURGICAL HISTORY Please list all surgeries/procedures including date(s)

_____

_____

FAMILY HISTORY

Is there any family History of Cancer? Yes / No Please specify the type and relative affected:

_____

_____

If your family has a history of any of the following indicate the family member by : '**M**'other '**F**'ather '**S**'ister '**B**'rother

( )Alcoholism_____
( )Blood Clots_____
( )Bleeding Disorders_____
( )Depression_____
( )Diabetes_____
( )Heart Disease_____
( )Hemochromatosis_____
( )High Blood Pressure_____
( )Kidney Problems_____
( )Manic Depressive Disorder _____
( )Obesity_____
( )Seizure Disorder _____
( )Stroke_____
Other:_____
_____

GYNECOLOGICAL HISTORY (WOMEN ONLY)

Are you or could you be Pregnant? Yes / No

Age that Periods began:_____Date of last Menstrual Period:_____Age at Menopause:_____

Number of Pregnancies #_____ Number of Births #_____ Number of Interrupted Pregnancies #_____

Age at first birth:_____ Are you using Hormonal Contraceptives: Yes / No If YES, #_____ of years

Have you ever used: ( )Birth Control Pills ( )Fertility Drugs ( )Hormone Replacement after Menopause

ROUTINE HEALTH MAINTENANCE

List if and when you had the following health maintenance testing done:

( )Colonoscopy When was most recent: _____

( )Mammogram When was most recent: _____

( )Pap Smear When was most recent: _____

( )PSA Blood test When was most recent: _____

Name:_____

REVIEW OF SYSTEMS (Please circle any that apply)

GENERAL INFORMATION
- Recent weight change
  - Gain or Loss
- Loss of appetite
- Persistent fevers
- Night sweats
- Enlarged lymph nodes

NEUROLOGIC
- Headaches
- Dizziness/ Blackouts
- Seizures
- Numbness or tingling
- Weakness or paralysis
- Visual problems
- Hearing problems

CHEST
- Pain
- Shortness of breath
- Cough
- Coughing up blood

MOUTH/ THROAT
- Pain or soreness
- Non-healing lesions
- Shifting teeth
- Change in fit of dentures
- Change in voice
- Trouble swallowing
- Neck mass
- Ear

GASTROINTESTINAL
- Abdominal or pelvic pain
- Nausea, vomiting
- Vomiting of blood
- Diarrhea
- Constipation
- Recent bowel changes
- Rectal bleeding or Black stool
- History of Diverticulitis or Colitis
- Yellow jaundice

MUSCULOSKELETAL
- Back pain
- Bone pain
- Swelling of an extremity

GENITOURINARY
- Urinary frequency
- Urinary pain
- Urinary burning

WOMEN ONLY
- Vaginal discharge
- Lump or mass in breast
- Breast pain

MEN ONLY
- Prostate problem
- Penile discharge
- Swollen testicle

Patient Signature_____

Nurse or Physician's Signature_____