ALLIANCE
Cancer Specialists

NEW PATIENT EVALUATION

Name: _____ DOB: _____

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

_____

_____

Pharmacy you typically use: _____ Phone Number: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Do you currently have a: **Living Will**: Yes___ No___ **Durable POA**: Yes___ No___ **DNR**: Yes___ No___
*If yes, please provide a copy

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 ( ) Widowed ( ) Divorced ( ) Separated

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 #_____years

( ) Cigarettes ( ) Cigars ( ) Chewing Tobacco ( ) Pipe ( ) e-Cigarettes ( ) Recreational Drug Use_____

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