ALLIANCE
Cancer Specialists

New Patient Information

Name: _____ DOB: _____ MRN: _____

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

_____

_____

Preferred Pharmacy: _____ 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 (Include adverse reaction if known): _____

SOCIAL HISTORY | Place a checkmark ☑ in the appropriate boxes

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Occupation: _____ Retired? ☐ Yes ☐ No

Exposure to Hazardous Materials? ☐ Yes ☐ No – If yes, please indicate below

☐ Asbestos ☐ Benzene ☐ Lead ☐ Radiation ☐ Other (please specify) _____

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

Tobacco Use: ☐ Never ☐ Former (Date Quit _____) ☐ Current Smoker _____ packs per day #_____years

Products Used:

☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ e-Cigarettes ☐ Vape ☐ Recreational Drug Use

Physical Activity Level:

☐ Sedentary ☐ Daily Activities ☐ Exercise: Frequency ☐ Occasional ☐ Regular ☐ Extensive

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CANCER HISTORY | Place a checkmark ☑ in the appropriate boxes if you have been diagnosed with any of the following.

- ☐ Bladder Cancer
- ☐ Bone Cancer
- ☐ Brain Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Esophageal Cancer
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Skin Cancer
- ☐ Small Intestine Cancer
- ☐ Stomach Cancer
- ☐ Uterine Cancer
- ☐ Other: _____
- ☐ Other: _____

MEDICAL HISTORY | Place a checkmark ☑ in the appropriate boxes if you have been diagnosed with any of the following.

- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Problems
- ☐ Cataracts
- ☐ Chronic Bronchitis
- ☐ Cirrhosis
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ COPD (Lung Disease)
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ Fibrocystic Breast
- ☐ GERD (Heartburn)
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Nerve/Muscle Disease
- ☐ Osteoporosis
- ☐ Polycythemia Vera
- ☐ Polymyalgia Rheumatica
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease: ☐ Hyper ☐ Hypo
- ☐ TIA (Transient Ischemic Attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

GYNECOLOGIC HISTORY (Women Only) | Please complete the following to the best of your ability.

Last Menstrual Period	Date:	Number of Pregnancies	
Birth Control ☐ Yes ☐ No	If Yes, Type:	Number of live births	
Age at first Menstruation		Number of abortions/miscarriages	
Age at Menopause		Your age when first child born	
Have you ever used ☐ Birth Control ☐ Fertility Drugs ☐ Hormone Replacement after menopause			

SURGICAL HISTORY | Please check if you have had any of the following surgeries, and the date of surgery if known.

☐ Appendectomy	Date:	☐ Cholecystectomy	Date:
☐ Arterial Bypass	Date:	☐ Hysterectomy	Date:
☐ Biopsy	Date:	☐ Splenectomy	Date:
☐ Back Surgery	Date:	☐ Other:	Date:

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FAMILY MEDICAL HISTORY | Indicate health problems in your immediate family members: Mother, Father, Sister, Brother

History of Cancer diagnosis in your immediate family.

Who?	Type?
Who?	Type
Who?	Type?

Family history of the following, please identify which family member: **M**-Mother, **F**-Father, **S**-Sister, **B**-Brother and indicate **age at time of diagnosis** if known.

Blood Clots	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Bleeding Disorder	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___
Heart Disease	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Diabetes	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___
High Blood Pressure	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Stroke	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___
Kidney Issues	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Seizures	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___
Other:	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Other:	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___
Other:	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___	Other:	☐ M ☐ F ☐ S ☐ B Age when diagnosed: ___

☐ I do not know my family history.