



New Patient Information

Welcome! The information you provide here will help us give you better care.
All of this information is confidential and protected.

Your Name: _____ Today's Date: _____

What doctor referred you to us? Or did you find us yourself? _____

Who is your Primary Care Provider? _____ City _____
(If you have your primary care doctor's full mailing address and fax number, we'd like a copy!)

Please list other doctors (other specialists) who should receive information about your visit here.

Doctor's Full Name	City (address and fax if available)	Specialty

Medical History

Are any of these conditions part of your history? Explain "YES" answers in space below.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Prior Radiation Therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No MRSA or other 'Hospital' Infections? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No OTHER CANCER now or in past? | <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus or Dermatomyositis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever or Heart Murmur? | <input type="checkbox"/> Yes <input type="checkbox"/> No Scleroderma or Rheumatoid Arthritis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve Replacement? | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis or Valley Fever? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Infection with HIV, or AIDS? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Infection with any Hepatitis Virus? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Clot or Pulmonary Embolism? | <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Abuse or Drug Addiction? |

List other **MEDICAL CONDITIONS, PAST ILLNESSES, and PAST SURGERIES**

Disease Prevention History

Last Pap smear? [] In last 12 months [] More than 1 year ago (date: _____) [] None

Ever have a colonoscopy for colon cancer detection? [] Yes (date: _____) [] No

Ever have a bone density (DEXA) scan to check for weak bones? [] Yes (date: _____) [] No

Breast Health History

Number of pregnancies _____ Ever take birth control pills? [] Yes [] No

Number of deliveries _____ If Yes, how many years total? _____

Your age at first child _____ Ever take estrogen after menopause? [] Yes [] No

Age at first period _____ If Yes, how may years total? _____

Age or date of last period _____ Did you breast feed? [] Yes [] No

Could you be pregnant? [] Yes [] No If Yes, how long (mo or yrs)? _____

What is your bra size? _____

Medication and Allergy History

[] Yes [] No Do you take aspirin, Plavix (clopidrogel), Warfarin (coumadin), or blood thinner?

If YES, please list below under CURRENT MEDICATIONS.

[] Yes [] No Do you have an ALLERGY or INTOLERANCE to any medication or substance?

If YES, please list the drug(s) and the allergic reaction:

Please list your CURRENT MEDICATIONS

Drug Name Dose Taken how often? Reason?

Table with 4 columns: Drug Name, Dose, Taken how often?, Reason? and 8 empty rows.

Occupation or Primary Activity _____

- Yes No Do you have a life partner or spouse?
Name: _____
- Yes No Does anyone live with you? Who? _____
- Yes No Have you ever used tobacco? Cigarettes _____ packs/day for _____ years.
 Yes No Still smoking? If not, when did you quit? _____
- Yes No Do you EVER drink alcohol? If "Yes" how many ounces per week? _____/week
 Yes No Did you ever drink alcohol IN THE PAST?
- Yes No Are you claustrophobic? If YES, are CAT scans tolerable? _____

Family Medical History

- Yes No Any relatives diagnosed with Breast Cancer? If YES, list below
- Yes No Any relatives diagnosed with Ovarian Cancer? If YES, list below
- Yes No Any relatives diagnosed with Colon Cancer? If YES, list below
- Yes No Any other cancers in Parents, Siblings, or Children? If YES, list below
- Yes No Any relatives with Blood Clots or Pulmonary Embolism? If YES, list below

Relative	What Cancer	Age at Diagnosis

Review of Current Symptoms

Have you experienced any of these problems during the past several months?

General

- Fevers, sweats or chills Yes No
- Weight change Yes No
- New fatigue Yes No
- Hot flashes Yes No
- Comments: _____

Gastro-Intestinal

- Rectal pain and/or bleeding Yes No
- Diarrhea, constipation, especially if NEW Yes No
- Nausea or vomiting Yes No
- Frequent indigestion or heartburn Yes No
- Hernia Yes No
- Ulcers Yes No

Eyes

- New vision trouble (floaters, etc) Yes No
- Other? Yes No

Comments: _____

Review of Current Symptoms (Continued – Page 4)

Have you experienced any of these problems during the past several months?

Ear/Nose/Mouth/Throat

- Pain or problems swallowing Yes No
Hearing changes Yes No
Loss of balance or coordination Yes No

Comments: _____

Heart-Related

- Chest pain Yes No
Leg swelling Yes No
Lightheadedness with activity Yes No

Comments: _____

Lung-Related

- Cough or coughing up blood? Yes No
Pain with breathing Yes No
Shortness of breath Yes No

Comments: _____

Bone and Muscle-Related

- Arm or leg weakness Yes No
Back or joint pain Yes No

Comments: _____

Endocrine

- Unusual sweating, thirst, hunger Yes No
Unusual Heat/cold intolerance Yes No

Psychiatric

- Disabling feelings of depression Yes No
Trouble sleeping Yes No
Disabling feelings of anxiety Yes No

Comments: _____

Share any other concerns or symptoms: _____

Genito-Urinary

- Excessively frequent urination Yes No
Pain or burning with urination Yes No
Blood in urine Yes No
Awakening at night to urinate Yes No
Urinary infections Yes No
Irregular menstrual bleeding Yes No
Vaginal bleeding, discharge Yes No
Pain with pelvic exam, intercourse Yes No

Comments: _____

Skin

- Change in skin color Yes No
Rashes Yes No
Skin cancers Yes No
Changes in skin, hair, nails or moles Yes No

Comments: _____

Brain and Nerve-Related

- Headaches Yes No
Seizures or unexplained fainting Yes No
Arm or leg numbness or tingling Yes No

Comments: _____

Hematologic/Lymphatic

- Easy bruising/bleeding Yes No
Swollen glands Yes No

Allergies and Immune system

- Recurrent infections Yes No
Life-threatening allergies, sensitivities? Yes No

Comments: _____

For Physician Use Only: I reviewed this information with the patient.

Physician Signature _____ Date _____

Dr. Tannehill Dr. Maggass Dr. Quiet Dr. Kuske