Pacific Cancer Care

*Advanced Treatment. Personalized Care.*

# Patient Intake Form

**Name**: _____ DOB: _____

Contact Information: (Please mark your preference)

☐ Home: _____ ☐ Cell: _____

☐ Work: _____

Referring Physician: _____

Reason for Referral: _____

Primary Care Physician: _____

Other Physicians You See: _____

## Medical History

_____

_____

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## Surgical History

| Surgery | Surgeon | Date |
|---|---|---|
| | | |
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## Family History

**If any blood relative has had any of the following conditions, please check and specify**

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Cancer (see separate form)
☐ Diabetes
☐ Emphysema/COPD
☐ Epilepsy/Seizure disorder
☐ Glaucoma
☐ Heart Disease
☐ High blood pressure
☐ High cholesterol
☐ Osteoporosis
☐ Stroke
☐ Thyroid disease

☐ Other Conditions:

_____

_____

_____

Name:

## Social History

Place of Birth: _____
Where do you live currently (and with whom?) _____
Occupation: _____ Retired ☐Yes ☐No
Volunteer Activities: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Children ☐Yes ☐No ☐Ages (if applicable) _____

Alcohol Use: ☐Never ☐Current (# of drinks/day) _____ ☐Former (# of drinks/day, Quit Date) _____
Have you ever been treated for Alcohol Abuse ☐Yes ☐No
Tobacco Use: ☐Never ☐Current (# of packs/day)_____ ☐Former (# of packs/day, Quit Date)_____
Drug Use: ☐Never ☐Former: Type/Frequency_____

## Medications

| Name | Dose | Indication | Ordering Physician |
|---|---|---|---|
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## Supplements/Alternative Medicines

_____

_____

_____

## Allergies (and Reaction)

_____

_____

Name:

## Review of Systems

**Please check ☐ if you have had any of the following**

### General
- ☐ Fevers
- ☐ Recent weight change
- ☐ Fatigue
- ☐ Night sweats
- ☐ Other_____

### Eye, Ear, Nose and Throat
- ☐ Eye pain
- ☐ Wear glasses/contacts
- ☐ Blurry or double vision
- ☐ Loss of vision
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Ear infection
- ☐ Nose bleeds
- ☐ Mouth Sores
- ☐ Sore throat
- ☐ Hoarseness or voice change
- ☐ Swollen neck glands
- ☐ Other_____

### Gastrointestinal
- ☐ Loss of appetite
- ☐ Bloating
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Red blood in stool
- ☐ Black/tarry stools
- ☐ Liver disease
- ☐ Other_____

### Skin
- ☐ Itching
- ☐ Rash
- ☐ Prior skin cancer
- ☐ Removal of skin lesions
- ☐ Other_____

### Heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain/angina
- ☐ Heart murmur
- ☐ Heart failure
- ☐ Palpitations/ skipped beats
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Other_____

### Lung
- ☐ Chronic Cough
- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Home oxygen
- ☐ Other_____

### Genitourinary
- ☐ Urinary infections
- ☐ Frequent urination
- ☐ Difficulty urination
- ☐ Burning/painful urination
- ☐ Bloody or pink urine
- ☐ Kidney problems/failure
- ☐ Kidney stones
- ☐ Prostate enlargement
- ☐ Impotence
- ☐ Sexual difficulty
- ☐ Other_____

### Muscle and Joint
- ☐ Arthritis
- ☐ Chronic neck pain
- ☐ Chronic back pain
- ☐ Broken bones/fractures
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Other_____

### Neurological
- ☐ Migraines
- ☐ Headaches
- ☐ Stroke
- ☐ Seizures
- ☐ Dizziness
- ☐ Head injury
- ☐ Falling
- ☐ Other_____

### Blood Disorders
- ☐ Bruising
- ☐ Anemia
- ☐ Prior transfusions
- ☐ Blood clots
- ☐ HIV/AIDS
- ☐ Other_____

### Endocrine
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Hormone problem
- ☐ Other_____

### Women Only
- ☐ Breast lump
- ☐ Breast pain
- ☐ Prior breast biopsy
- ☐ Nipple discharge
- ☐ Hot flashes
- ☐ Vaginal discharge

Age at first period ___
Date of last period ___
- ☐ Heavy periods
- ☐ Frequent periods

Date of last PAP _____
☐ Normal ☐ Abnormal

# of pregnancies ____
# of children _____
Age at first delivery___

Name:

## Vaccination History

Flu Vaccine ☐ Yes ☐ No Date _____

Pneumovax (Pneumonia) Vaccine ☐ Yes ☐ No Date _____

Zostavax (Shingles) Vaccine ☐ Yes ☐ No Date _____

## Pharmacy Information

Name of Local Pharmacy and Address: _____

Your mail order Pharmacy (if applicable) Subscribe Name: _____

Subscriber ID: _____

Your Home Care Agency (if applicable) _____

## Any other health issues or concerns that our staff should be made aware of?

_____

_____

_____

_____

_____

_____

Thank you for completing this form

Signature: _____