TORRANCE MEMORIAL
HUNT CANCER INSTITUTE

Addendum to Initial Patient Intake Form:
Association of South Bay Surgeons

Patient Name: _____ **DOB**: _____
(Last) (First) (MI)

Today's Date: _____

Who is your referring doctor? _____ **Phone**: _____

Reason for visit: Abdominal pain ☐ Bowel/bladder changes ☐ Difficulty swallowing ☐ Gastric Reflux ☐

Imaging/Procedure follow-up ☐ Pre-Op ☐ Post-Op ☐ Rectal bleeding ☐ Other _____

History of Family diseases
['M' for Mother,
'P' for Paternal =Father]

	YES
Diabetes ……	☐
Gallstones ……	☐
Heart disease ……	☐
Inflammatory bowel disease	☐
Kidney disease ……..……..	☐
Obesity ……..	☐
Psychological ……	☐
Pulmonary disease	☐
Stroke ……	☐
Thyroid disease ……	☐

Have you had any of the following?

	YES		YES
High Blood Pressure……..	☐	Esophageal Reflux……...	☐
Acute Myocardial Infarction…..	☐	Asthma……	☐
A-Fib……..	☐	COPD……...	☐
Coronary Artery Disease……	☐	Sleep Apnea…….	☐
Stroke…….	☐	Osteoporosis…….	☐
Venous Thrombus (DVT) …….	☐	Renal Failure……	☐
Cancer, Type:_____	☐	Blood Disorder, Type:_____	☐
High Cholesterol……	☐	HIV Infection……...	☐
Diabetes Mellitus……..	☐	Hepatitis……	☐
Thyroid Disorder, Type:_____	☐	Other: _____	☐

When was your last flu vaccination? : _____

(Female patients age 40 or older) When was your last mammogram? _____

(Patients ages 50-75) When was your last colonoscopy? _____

(Patients ages 65 or older) Have you ever received a pneumonia vaccination? Y ☐ N ☐ Date: _____

Patient Signature: _____**Date**: _____

If completed by someone other than patient:

Name: _____ **Relationship**: _____