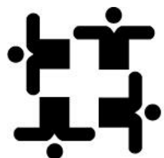

Hunt Cancer Institute

Initial Patient Intake Form

Patient Registration

Today's Date _______________

Patient Name ____

(Last) (First) (Middle)

Address ____

Is this a Skilled Nursing Facility? ☐ Yes ☐ No

Home phone ( )________________ Cell phone ( )________________ Email ______________________________

Date of birth ____________________________ (mm/dd/yyyy) SSN# (optional)________________________________

Current gender identity: ☐ Male ☐ Female ☐ Transgender Height: _________ Weight: __________

Employer ____ Occupation: ____________________________

Business address ____ Work phone ( )______________________

Spouse's name _________________________ Employer: ___________________________ Work phone ( )___________________

Physicians

Name of Primary Care Provider (PCP) ____________________________________ Tel ______________________________

Address ____ Fax ______________________________

Referring physician (if not PCP) ____ Tel ______________________________

Address ____ Fax ______________________________

Emergency Contact Information

Name of nearest friend/relative not living with you ________________________________ Tel ________________________________

Address ____ Relationship to you ______________________________

Insurance Information

Name of insured ____ Relationship to Patient ___________________________

Address ____ Contact phone _________________________________

Name of employer ____ Work phone ____________________________________

Primary Insurance Company _________________________________ ID#______________________ Group#____________________

Address ____ City ________________________ State _____ Zip ___________

Secondary Insurance Company _______________________________ ID#______________________ Group#____________________

Address ____ City ________________________ State _____ Zip ___________

Pharmacy Information

Pharmacy: _________________________ Address: ____ Tel: ____________________

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Allergies: (to medications, food, dust, pollen, adhesive/tape, etc.) ____

Type of reaction: ____

Latex Allergy

When exposed to latex or rubber (including rubber gloves, balloons, condoms), do you suffer runny nose, watery eyes, wheezing, or rash?

☐ No ☐ Yes, explain: ____

Do you have spina bifida or repeated catheterizations from congenital defects? ☐ No ☐ Yes, please explain: ____________

____

Do you have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)? ☐ No ☐ Yes, explain: ____

Current Medications (include non-prescription):

Name of Medication	Strength of dose (mg)	How Taken	How Often	Last Dose Taken	Reason for Use

*If more space is needed, please attach a list to this page.

Are you taking any of the following herbal medicines? ☐ Echinacea ☐ Ephedra ☐ Garlic ☐ Ginkgo biloba ☐ Ginseng ☐ Kava ☐ St. John's Wort ☐ Valerian Root ☐ Other: ____

Any medication side effects? ☐ No ☐ Yes, explain: ____

____

____

Social History

Married ☐ Single ☐ Divorced ☐ (Year_____) Widowed ☐ (Year_____) Birthplace ________________________________

Present occupation ______________________________________ Previous occupations ______________________________

Education ____ Spouse's occupation _________________________________

Persons currently living in your home ____

Do you have a Living Will / Advanced Directive / POLST? ☐ No ☐ Yes, please provide copy

Do you have transportation needs? ☐ Yes ☐ No Please describe: ____

Language Spoken

Primary Language __________________________ Preferred language of communication (if different)_____________________

Needs Interpreter ☐ Yes ☐ No, I'm comfortable communicating in English

Religion / Culture

What is your religious affiliation (optional)? ____

Are there religious/cultural beliefs that will/could impact your treatment? ☐ Yes ☐ No

Please explain: ____

Self-Reporting History & Physical

Reason for this visit (chief complaint): ____

____

Onset of illness: _______________ Date: _______________ Symptom(s): ____

Pain? ☐ No ☐ Yes, Pain scale: **1 (low) → 10 (high)** __________

Do you have any known genetic/predisposition to disease? ☐ No ☐ Yes, explain: ______________________________________

____

Medical History:

(Patients ages 50-75) When & where was your last colonoscopy? ____

Illness / Injury Date

____

____

____

____

Surgeries / Hospitalizations (starting with most recent) Date

____

____

____

____

*If more space is needed, please attach a list to this page.

Any prior problems with anesthesia? ☐ No ☐ Yes, explain:____

Medical/Prosthetic/Cosmetic Implants or Devices? ☐ No ☐ Yes, explain:____

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Any prior Cancer diagnosis? ☐ No ☐ Yes, type of cancer: ______________________________

______________________________ Date diagnosed: ____________

Was a Biopsy performed (tissue/bone marrow)? ☐ No ☐ Yes, facility name: ____________________

Physician name: ______________________________ Date of service: ______________

Was a Surgery performed? ☐ No ☐ Yes, facility name: ______________________________

Physician name: ______________________________ Date of service: ______________

Have you ever received Chemotherapy ☐ Yes, **Hormone Therapy** ☐ Yes**, or Immunotherapy** ☐ Yes**?**

Medical Oncologist's Name ______________________________

Address ______________________________

Medication ______________________________ Date Received ______________

Medication ______________________________ Date Received ______________

Have you ever received Radiation Therapy? ☐ No ☐ Yes, provide date: ____________________

Radiation Oncologist's Name: ______________________________

Address ______________________________

To what part of the body did you receive radiation therapy? ______________________________

Female

Are you now, or is there a possibility that you may be pregnant? ☐ No ☐ Yes **Patient Initials**: _______ Date: ________

Number of pregnancies ________ Deliveries ________ Miscarriages ________ Did you breastfeed? ☐ Yes ☐ No

Have you ever take hormones (birth control pills, estrogen, androgens, etc.)? ☐ Yes ☐ No

If yes, what type and for how long? ______________________________

Do you still have menstrual periods? ☐ No ☐ Yes, date of last period: ____________ Age periods started: ________

Frequency (days): __________ How many days do periods last? __________ Any pain with periods? ☐ No ☐ Yes

Date of last pap smear & results: ______________________________

(Female patients age 40 or older) When & where was your last mammogram? ____________________

Habits

Smoking? ☐ No ☐ Yes How many packs per day? ________ For how many years? ________ Quit date: ________

Alcohol? ☐ No ☐ Yes What type?____________________ How many drinks per week? ______________

Have you ever used "street" (illegal) intravenous drugs? ☐ No ☐ Yes Recreational drugs? ☐ No ☐ Yes

Have you ever been tested for HIV/AIDS virus? ☐ No ☐ Yes, provide the result: ____________________

Have you ever been tested for Hepatitis? ☐ No ☐ Yes, provide the result: ______________________________

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Health History

		YES
General	Arthritis	☐
	Chills/night sweats	☐
	Difficulty sleeping	☐
	Dry mouth / dehydration	☐
	Fatigue	☐
	Loss of appetite	☐
	Musculoskeletal/joint pain/aches	☐
	Osteoporosis	☐
	Weight change	☐
Skin	Bruising	☐
	Hair loss	☐
	Jaundice	☐
	Moles / abnormal pigmentation	☐
	Nail changes	☐
	Redness/rash	☐
	Swelling	☐
Eyes	Cataracts/glaucoma	☐
	Redness / pain / injury	☐
	Swelling	☐
	Vision changes	☐
Ears	Discharge	☐
	Hearing loss	☐
	Ringing in ears	☐
Nose	Bleeding	☐
	Discharge	☐
Throat	Difficulty swallowing / pain	☐
	Mouth sores	☐
	Swelling/hoarseness	☐
Immuno-logic	Autoimmune disease (Lupus, Rheumatoid Arthritis)	☐
	Fevers	☐
	Infections	☐
	Scleroderma	☐
	Swollen glands / lymph nodes	☐
Breast	Bleeding	☐
	Discharge	☐
	Lumps	☐
	Pain	☐
Lungs	Asthma	☐
	Blood in sputum	☐
	COPD	☐
	Cough	☐
	Emphysema	☐
	Oxygen tank use	☐
	Shortness of breath	☐
	Sleep apnea / CPAP machine	☐
	Tuberculosis	☐

		YES
Heart	Chest pain	☐
	Heart problems / disease / MI	☐
	Heart palpitations / murmur	☐
	High blood pressure	☐
	Irregular heart beat / A-fib	☐
	Pacemaker / Defibrillator	☐
Gastro-intestinal	Abdominal / stomach pain	☐
	Black / bloody stool	☐
	Bowel changes	☐
	Constipation	☐
	Diarrhea	☐
	Heartburn / reflux	☐
	Hemorrhoids	☐
	Nausea	☐
	Rectal bleeding	☐
	Ulcerative colitis / Crohn's disease	☐
	Vomiting	☐
Urinary	Bladder problems	☐
	Blood in urine	☐
	Burning / difficult urination	☐
	Frequent urination / incontinence	☐
	Kidney disease / dialysis	☐
	Urinating at night, 1 2 3 4 5 times	☐
Genital	Ovary / uterine problems	☐
	Prostate problems	☐
	Scrotal pain / mass	☐
	Problems with erection	☐
	Vaginal discharge / pain	☐
Hormonal	Diabetes	☐
	Heat / cold intolerance	☐
	High cholesterol	☐
	Thyroid problems	☐
Blood	Anemia / blood disorder	☐
	Blood clots / DVT	☐
	Low blood counts	☐
Neurologic	Balance issues / falls	☐
	Dizziness / fainting spells	☐
		☐
		☐
		☐

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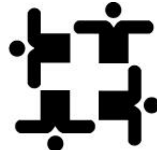
FAMILY HISTORY - Please list all family members with cancer

Relation	**Male/Female**	**Deceased?**	**Current age, or age at death**	**Cancer type**	**Age at Cancer Diagnosis**
Children	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Brothers & Sisters	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Father		☐ Yes / ☐ No			
Mother		☐ Yes / ☐ No			
Paternal Grandfather		☐ Yes / ☐ No			
Paternal Grandmother		☐ Yes / ☐ No			
Paternal Aunts and Uncles	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Paternal Cousins	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Maternal Grandfather		☐ Yes / ☐ No			
Maternal Grandmother		☐ Yes / ☐ No			
Maternal Aunts and Uncles	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Maternal Cousins	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			
Additional relatives (ex. nieces, nephews, great-grandparents)	☐ M / ☐ F	☐ Yes / ☐ No			
	☐ M / ☐ F	☐ Yes / ☐ No			

Mother's ancestry (countries of origin): ______________Father's ancestry (countries of origin): _______________
Are you of Ashkenazi Jewish descent? ☐ Yes / ☐ No
Have any of your family members ever had genetic testing? ☐ Yes / ☐ No If yes, which relative(s) had genetic testing and what were their results? (ie: Sister has BRCA1 mutation) ____________________________________



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PLEASE LIST ALL OF YOUR PRESENT PHYSICIANS:

	Specialty: ______________ ☐ Seen for current problem	Specialty: ______________ ☐ Seen for current problem	Specialty: ______________ ☐ Seen for current problem
Name			
Address			
Phone #			
	☐ Please send reports to this physician ☐ Do not send reports	☐ Please send reports to this physician ☐ Do not send reports	☐ Please send reports to this physician ☐ Do not send reports

Should we contact someone to obtain your medical records?

	Physician / Hospital / Other Facility	Physician / Hospital / Other Facility	Physician / Hospital / Other Facility
Name			
Address			
Phone #			
Study (CT, MRI, biopsy, etc.)			

Is there any other information about your health you would like to add? ☐ No ☐ Yes ____________________

____

____

____

____

Patient Signature: ____ **Date**: ___________________________

If completed by someone other than patient:

Name: ____ **Relationship**: ______________________