New Patient & Family History

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Gender: ☐ Male ☐ Female Marital Status: (Please check one) ☐ Married ☐ Single ☐ Divorce ☐ Widow ☐ Other:_____

Home Address: _____
Address City State Zip Code

Telephone (1st call): ( ) _____ Telephone (2nd call): _____

Referring Physician: _____
Address City State Zip Code

Primary Care Physician: _____
Name Address City State Zip Code

Number of Children:_____ Ages:_____

What is your primary language? _____

Who lives with you? (Please check all that apply) ☐ I live alone ☐ Spouse ☐ Children ☐ Parents ☐ Friend ☐ Other:_____

Who helps at home?_____

Person(s) with your Medical Record Access: _____
Name Relationship Telephone

Have you executed Medical Power of Attorney, Directive to Physicians (Living Will) or Out-of-Hospital Do Not Resuscitate forms? ☐ Yes ☐ No

Would you like to learn about our Advance Care Planning Program, My Choices, My Wishes? ☐ Yes ☐ No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? ☐ Yes ☐ No

I am currently: Working: ☐ Yes ☐ No Work Schedule is: ☐ Full-time ☐ Part-time ☐ Sick Leave ☐ Retired ☐ Disability

What type of work do you currently do or have done?_____

Do you use any of the following? (Please check all that apply)

Alcohol: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Sunscreen: ☐ Yes ☐ No

How much time do you spend exercising each week?_____ What type of exercise?_____

Do you need to use any of the following? (Please check all that apply) ☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen

☐ Other: _____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: ☐ Skin ☐ Mole ☐ Other:_____

Female: Breast ☐ Yes ☐ No Have you ever been trained properly for breast self-exam? ☐ Yes ☐ No

Male: Testicles ☐ Yes ☐ No Have you ever been trained properly for testicular self-exam? ☐ Yes ☐ No

Are you diabetic? ☐ Yes ☐ No If yes, what type:_____

If yes, how is it controlled: ☐ Diet ☐ Oral Medications ☐ Insulin ☐ Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): ☐ Yes ☐ No If yes, how is it controlled:_____

Reproductive History:

Female: Number of pregnancies:_____ Number of children: _____ Age at first pregnancy:_____

Did you breast feed: ☐ Yes ☐ No If yes, how many months (approximate): _____

Age at first period:_____ Age at menopause: _____ Age at last period:_____

Hysterectomy: ☐ Yes ☐ No Ovaries intact: ☐ Yes ☐ No If *no*, please explain:_____

Hormone use: ☐ Yes ☐ No Sex Drive: ☐ Yes ☐ No Method of birth control:_____

Male: Impotence (Erectile Dysfunction): ☐ Yes ☐ No Sex Drive: ☐ Yes ☐ No

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____Date of Birth:_____
Last First Middle or Maiden

What is your understanding of why you are being seen:_____

_____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months:_____

_____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female:
Last mammogram:_____ Last bone density scan:_____
Last pap smear: _____ Last pneumonia vaccine:_____
Last colonoscopy:_____

Male:
Last colonoscopy:_____ Last PSA screening:_____
Last prostate exam:_____ Last pneumonia vaccine:_____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal **(P) = Paternal** (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	☐Living ☐Deceased		Grandmother (P)	☐Living ☐Deceased	
Father	☐Living ☐Deceased		Grandfather (P)	☐Living ☐Deceased	
Children	☐Living ☐Deceased		Aunt(s)	☐Living ☐Deceased	
Brother(s)	☐Living ☐Deceased		Uncle(s)	☐Living ☐Deceased	
Sister(s)	☐Living ☐Deceased		Cousin(s)	☐Living ☐Deceased	
Grandmother (M)	☐Living ☐Deceased		Other:		
Grandfather (M)	☐Living ☐Deceased		Other:		

Patient Signature:_____Date:_____

If someone other than the patient completed this form, please give name & relationship:_____
Name Relationship

Nurse Name: _____Signature:_____Date Reviewed:_____

Please return completed form to the appropriate physician's office.