cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

Today's Date: _____

NEW PATIENT HISTORY FORM

(Please print. Thank you)

Patient Name: _____ **MRN #** :_____

DOB: _____/_____/_____ **Age**: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Transgender:** ☐ **M to F** ☐ **F to M**

SSN: _____ **Phone**: (_____)_____**Cell Phone**: (_____)_____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Secondary Address: _____

City: _____ **State**: _____ **Zip Code**: _____

May we leave a message on your answering machine / voicemail? ☐ **Yes** ☐ **No**

Email Address: _____ **May we email you?** ☐ **Yes** ☐ **No**

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American

☐ Asian/ Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ **Work Phone**: (_____)_____

Relationship Status : ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home

☐ Winter Resident ☐ Year Round Resident

Children: ☐ Yes ☐ No **If yes, how many?** _____

Primary Care Physician: _____ **Phone #:** _____

Referring Physician (if different): _____ **Phone #:** _____

Please list any additional physicians you see: (Include Phone #):

_____ **Phone #:** _____

_____ **Phone #:** _____

_____ **Phone #:**_____

_____ **Phone #:** _____

Patient Initials _____

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Emergency Contact Name: _____

Relationship: _____ **Phone #:** _____

Durable Power of Attorney for Healthcare: ☐ No ☐ Yes _____

Relation to you: _____

Living Will for Healthcare: ☐ No ☐ Yes* *Please provide copy for your records

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ **Policy holder's SSN**: _____

Policy holder's employer: _____

Insurance ID #: _____ **Group #:**_____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ **Policy holder's SSN**: _____

Policy holder's employer: _____

Insurance ID #: _____ **Group #:**_____

Does plan have prescription coverage? ☐ Yes ☐ No

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials _____

cCARE
CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Reason For This Visit: _____

_____

_____

Medical History: (Check the items that apply to you, currently or in the past)

	Date of Diagnosis		Date of Diagnosis
☐ Anemia	_____	☐ GERD/Heartburn	_____
☐ Bleeding Disorder	_____	☐ Hiatal Hernia	_____
☐ Blood Clots	_____	☐ Gallstones	_____
☐ Blood Disorder	_____	☐ Cirrhosis of Liver	_____
☐ Frequent infections	_____	☐ Hepatitis A/B/C	_____
☐ HIV/AIDS	_____	☐ Pancreatitis	_____
☐ Diabetes – Type I, Type II	_____	☐ Kidney Stones	_____
☐ Thyroid Disease	_____	☐ Kidney Disease/Failure	_____
☐ High Blood Pressure	_____	☐ Frequent UTI	_____
☐ High Cholesterol	_____	☐ Enlarged Prostate	_____
☐ Atrial Fibrillation	_____	☐ Lupus-Autoimmune	_____
☐ Congestive Heart Failure	_____	☐ Reynaud's Syndrome	_____
☐ Heart Attack – MI	_____	☐ Rheumatoid Arthritis	_____
☐ Heart Disease	_____	☐ Osteoporosis	_____
☐ Rheumatic Fever	_____	☐ Fracture	_____
☐ Heartburn/Reflux	_____	☐ Stroke	_____
☐ Heart Murmur	_____	☐ Neuropathy	_____
☐ Peripheral Vascular Disease	_____	☐ Parkinson's disease	_____
☐ Asthma	_____	☐ Paralysis	_____
☐ Chronic Lung (COPD)	_____	☐ Seizures	_____
☐ Pneumonia/Bronchitis	_____	☐ Migraines	_____
☐ TB (Tuberculosis)	_____	☐ Shingles	_____
☐ Sleep Apnea	_____	☐ Glaucoma/Cataracts	_____
☐ Colon Polyps	_____	☐ Hearing Loss	_____
☐ Crohn's Disease	_____	☐ Cancer	_____
☐ Diverticulitis	_____	☐ Anxiety	_____
☐ Irritable Bowel Syndrome	_____	☐ Depression	_____
☐ Ulcerative Colitis	_____	☐ Other Psychiatric conditions	_____
☐ Stomach Ulcers	_____	Type	_____

Other Medical History: _____

_____

Past Cancer or Hematology History:

Type _____ **Date Diagnosed** _____ **Treating Physician** _____

Treatment (Type, Date, and location of treatment) _____

_____

Patient Initials _____

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Review of Symptoms: (Please check any **CURRENT** symptoms you have.)

General:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred vision
- ☐ Double vision
- ☐ Changes in vision

Ears, Nose, Throat:
- ☐ Hard of hearing or deaf
- ☐ Ringing in ears
- ☐ Enlarged lymph nodes
- ☐ Chronic sinus problems
- ☐ Sore throat
- ☐ Mouth pain/sores

Changes/Difficulty in:
- ☐ Taste
- ☐ Smell
- ☐ Voice

Cardiovascular:
- ☐ Chest pain/pressure
- ☐ Palpitations
- ☐ Irregular heart beat

Respiratory:
- ☐ Chronic or frequent cough
- ☐ Bloody sputum
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:
- ☐ Difficulty or painful swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Lump or sensation in throat
- ☐ Food sticking
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Black or tarry stools
- ☐ Loss of stool/fecal accident
- ☐ Poor appetite

Genitourinary:
- ☐ Pelvic pain
- ☐ Incontinence
- ☐ Burning or pain on urination
- ☐ Blood in Urine
- ☐ Difficult urination
- ☐ Men: prostate problems

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle pain

Neurological:
- ☐ Numbness, tingling
- ☐ Arm or leg weakness
- ☐ Light-headed, dizzy
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Tremors
- ☐ Falls

Skin:
- ☐ Rashes or itching
- ☐ Change in skin color or moles
- ☐ Varicose veins

Psychiatric:
- ☐ Anxiety/agitation
- ☐ Depression
- ☐ Crying for no reason
- ☐ Difficulty sleeping
- ☐ Alcoholism
- ☐ Drug problem (now/past)

Hematologic:
- ☐ Easy bruising
- ☐ Gum or nose bleeding
- ☐ Blood transfusion in past

When_____

Allergies/Immunology:
- ☐ History of chronic infections
- ☐ History of allergies

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Weight problem
- ☐ Hot flashes

Breast:
- ☐ Pain/lump
- ☐ Discharge
- ☐ Rash

Gynecology:
- ☐ Age at start of menses _____
- ☐ Last menstrual period

_____
- ☐ Vaginal discharge
- ☐ Menstrual irregularity or abnormal bleeding
- ☐ Menopause Age: _____
- ☐ Use of hormones
  - ☐ Birth control, how long? _____
  - ☐ Hormone replacement therapy How long? _____

Patient Initials _____

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Family Medical History: Indicate any family members with cancer, blood disease or other disease.

	AGE	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No

Please list: _____

_____

_____

Past Surgical History: (Please check any of the surgeries and/or procedures that you have undergone)

	Performing Physician		Performing Physician
☐ Coronary Bypass	_____	☐ Knee Replacement	_____
☐ Angioplasty	_____	☐ Rotator Cuff Repair	_____
☐ Pacemaker	_____	☐ Cataract	_____
☐ Cardiac Valve Surgery	_____	☐ Gallbladder Surgery	_____
☐ Hemorrhoidectomy	_____	☐ Hysterectomy	_____
☐ Prostate Operation	_____	☐ Prostatectomy	_____
☐ Hernia Repair	_____	☐ Appendectomy	_____
☐ Tonsillectomy	_____	☐ Hip Replacement	_____
☐ Mastectomy	_____	☐ Lumpectomy	_____

Other Operations: _____

Social History

Tobacco Use: (Present and/or past)

☐ **Never smoked**

☐ **Quit smoking** **When?** _____ **How many years did you smoke?** _____yr(s) **How many packs?** _____/day

☐ **Currently smoke** ☐ **Cigarettes** ☐ **Pipe** ☐ **Cigars** ☐ **Electronic cigarettes**

How many packs? _____/day **How many years?** _____

☐ **Chewing tobacco** ☐ **Current** ☐ **Past** **How long?** _____

Alcohol Use: (Present and/or past)

☐ **Non drinker**

☐ **Beer** number of bottles _____ per ☐ **Day** ☐ **Week** ☐ **Month**

☐ **Wine** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**

☐ **Liquor** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**

Recreational Drug Use: (Present and/or past)

☐ **No**

☐ **Present** **What type?** _____ **How often?** _____

☐ **Past** **What type?** _____ **How often?** _____

cCARE
CALIFORNIA CANCER ASSOCIATES FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Health Maintenance:

Sigmoidoscopy/Colonoscopy tests: ☐ Yes ☐ No Date: _____
Findings: _____

Last Esophagogastroduodenoscopy: _____

Last Mammogram: _____ Abnormal Mammogram? When? _____

Last Pelvic or Pap Exam: _____ Abnormal Pap? When? _____

Last Bone Density test: _____

Vaccines: (Please check if vaccine was received, and last date it was administered)

☐ Influenza shot Date: _____ ☐ Shingles shot Date: _____

☐ Pneumococcal Vaccine ☐ PCV13 ☐ PPSV23 ☐ Other _____

Date: _____

Lab Work:

Laboratory: _____

Date: _____ Ordering Physician _____

_____ _____

_____ _____

_____ _____

_____ _____

Scans/imaging/procedures: (Example: MRIs, CTs, PET/CTs, Echocardiograms, Biopsies, etc.)

Type	Date	Facility	Ordering Physician

Patient Initials _____

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

NEW PATIENT HISTORY FORM

Patient Name: _____ **MRN #** _____

Allergies and Sensitivities:

☐ No known allergies ☐ No known drug allergies

Allergy	**Reaction**

All Medications:

Name	**Strength/Frequency**	**Prescriber**

All Non-prescription Medication Including Vitamins and Herbs:

Pharmacy_____**Address**_____ **Phone#**_____

Patient Initials _____