MEADVILLE MEDICAL CENTER

Yolanda G. Barco ONCOLOGY INSTITUTE

Yolanda G. Barco Oncology Institute
16792 Conneaut Lake Road
Meadville, PA 16335
Phone (814) 373-2335 Fax (814) 373-2338

NEW PATIENT INTAKE FORM

First Name: _____Middle Name: _____Last Name: _____

Do you have a nick name that you prefer to be called by? _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Preferred number to contact: ☐Home ☐ Cell ☐ Work

May we contact you at work? ☐ Yes ☐ No

May our staff leave a detailed message or a call back number? ☐ Yes ☐ No

Sex: _____ Date of Birth: _____ Age: _____

Referring Physician's Name: _____ Family Physician's Name: _____

Pharmacy Name & Phone Number_____

1. In your own words tell us about your diagnosis and why you are here.

_____
_____
_____
_____

2. Have you ever been diagnosed with cancer? ☐ No ☐ Yes (If yes, please explain what type.)

_____
_____

3. Have you had chemotherapy in the past?

☐ No
☐ Yes When_____
Where_____
Physicians Name_____

4. Have you had radiation therapy in the past?

☐ No
☐ Yes When_____

Where_____
Physicians Name_____

5. Have you had surgeries in the past? ☐ No ☐ Yes (If yes, list surgeries below)

Type of Surgery	Year of Surgery

6. Please list ALL medications that you are currently taking, including non-prescriptions, vitamins, and herbal supplements. Please bring your medications with you, unless you have a printed list.

******If you already have a printed list of your medications, it can be copied and attached to this.*

Drug Name	Dose Size	Times per Day	Length of Time Taken

7. Do you have any allergies? ☐ No ☐ Yes (if yes, list below)

_____ Reaction_____
_____ Reaction_____

8. Please check and list any alternative health treatments you currently use.

☐ Chiropractor ☐ Nutritionist ☐ Prayer ☐ Acupuncture ☐ Holistic ☐ Yoga

Other Remedies_____

9. What is your current marital status?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Significant Other

10. What is your highest level of education?

□Did not graduate from High School
□High School
□ Vo-Tech School
□ College, number of years_____
□Graduate School
Comments: _____
_____

11. Are you presently employed? □Unemployed □Currently working □Retired

Current occupation_____
Previous occupations_____
_____

12. What is your tobacco/smoking history?

Do you currently smoke? □No □Yes

Did you smoke at any time? □No □Yes

Would you like help on quitting? □ No □ Yes

*If yes to either question; how many years? _____ How many packs per day? _____
*If you smoked at any time; when did you quit? _____
Have you used any other tobacco products? *Check all that apply.*
□Snuff □Chewing tobacco □ Pipe □ Cigars

Have you used recreational drugs? □No □Yes

*If yes, please describe the type of drug and frequency_____

13. What is your alcohol history?

Amount of alcohol (including beer, wine, and liquor) drinks per day, week, or month
_____

Have you ever been treated for alcohol abuse? If yes, when? _____

14. What is your exercise history?

☐ Exercise daily ☐ Occasional activity ☐ Do not exercise
Details_____

15. What is your dietary history?

List special diet you follow. _____

_____

List any recent change in eating habits. _____

16. Do you have any history of cancer in your family? (Maternal/paternal-grandparents, parents, brothers, sister, and/or children?)

RELATION	TYPE OF CANCER	AGE DIAGNOSED	ALIVE OR DECEASED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History

17. Have you ever had a blood transfusion?

Have you ever had a blood transfusion ☐ No ☐ Yes (If yes, please explain why and when the last one was.)_____

_____

_____

18. Have you ever had the pneumococcal vaccine? ☐ No ☐ Yes (if yes, when? _____)

19. Have you ever had the influenza vaccine? ☐ No ☐ Yes (if yes, when? _____)

20. Do you or have you *ever* had any of the following? (Check all that apply)

☐ AIDS/HIV
☐ Anxiety/Panic Attacks
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar Disorder
☐ Bladder Infection
☐ Breast Disease
☐ Bypass or Stents
☐ Chronic Diarrhea
☐ Colonoscopy
☐ Colon Polyps
☐ Colostomy/Ileostomy
☐ Congestive Heart Failure
☐ Crohn's Disease
☐ COPD
☐ Depression
☐ Diverticulitis
☐ Emphysema
☐ Enlarged Prostate
☐ Epilepsy
☐ Fatigue
☐ Gallstones
☐ GERD/Reflux
☐ Glaucoma
☐ Headaches
☐ Heart attack (year) _____
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Hysterectomy
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Migraines
☐ Motion Sickness
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker/Defibrillator
☐ Parkinson's disease
☐ Pelvic Inflammatory Disease
☐ Phlebitis/Blood Clots
☐ Polio
☐ Pneumonia
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Schizophrenia
☐ Sexually Transmitted Disease _____
☐ Sleep Apnea
☐ Stroke
☐ Swelling in extremities
☐ *L* ☐ *R* ☐ *Upper* ☐*Lower*
☐ Thyroid Disease
☐ *Low or* ☐ *High*
☐ Tuberculosis

☐ Type I Diabetes (years)____ ☐ Valve Replacement ☐ Urostomy
☐ Type II Diabetes(years)____ ☐ Ulcer ☐ Other_____

21. Have you had any of these symptoms in the *last 4 weeks*? (check all that apply)

General
_____ Fever
_____ Poor Appetite
_____ Weight Loss
_____ Fatigue
_____ Chills
_____ Night Sweats

Eyes
_____ Blurry Vision
_____ Double Vision
_____ Cataracts
_____ Glaucoma

Respiratory
_____ Cough
_____ Emphysema
_____ Asthma
_____ Chronic Bronchitis
_____ Oxygen Use
_____ Shortness of Breath
_____ Coughing Up Blood
_____ Wheezing
_____ Tuberculosis
_____ Have you ever been intubated?

Ear/Nose/Throat
_____ Sore throat
_____ Difficulty Swallowing
_____ Bleeding Gums
_____ Dentures
_____ Hoarseness/ Change In Voice
_____ Nosebleeds
_____ Hearing Loss

Cardiac
_____ Heart Attack
_____ High Blood Pressure
_____ Chest Pain/Angina
_____ Palpitations/ Fast Heartbeat
_____ Pacemaker/Defibrillator
_____ Bypass or stents
_____ Murmur
_____ Valve Replacement
_____ Congestive Heart Failure
_____ Swelling in legs
_____ Swelling in arms

Skin
_____ Rash
_____ Itching
_____ Sensitivity to Sun Exposure
_____ Skin Cancer

Musculoskeletal
_____ Artificial Joints/Limbs
_____ Fractures
_____ Arthritis
_____ Back Pain
_____ Use Cane/Walker
_____ Osteoarthritis
_____ Neck Pain

Gastrointestinal
_____ Nausea
_____ Vomiting
_____ Heartburn/ Indigestion/Reflux
_____ Ulcers
_____ Abdominal Pain
_____ Bloating
_____ Constipation
_____ Diarrhea
_____ Dark, Tarry Stools
_____ Blood In stools
_____ Change In stool size
_____ Colitis
_____ Inflammatory Bowel Disease
_____ Crohn's disease
_____ Irritable Bowel Syndrome
_____ Diverticulitis
_____ Colostomy/ Ileostomy
_____ Hemorrhoids
_____ Liver Disease

Urinary
_____ Incontinence (leaking/ unable to hold urine)
_____ Blood in Urine
_____ Painful Urination
_____ Frequency
_____ Urgency (can't wait)
_____ Foley catheter
_____ Urostomy
_____ Kidney stones
_____ Stents

Blood/Lymphatic
_____ Swollen Glands
_____ Bruise Easily
_____ Bleed Easily
_____ Blood Clots
_____ Anemia
_____ Blood Transfusions
_____ HIV

Neurologic
_____ Migraines
_____ Headaches
_____ Dizziness
_____ Confusion
_____ Seizures
_____ Numbness/tingling
_____ Stroke
_____ Blurred Vision
_____ Double Vision
_____ Sensitivity to Light

Psychosocial
_____ Anxiety
_____ Depression
_____ Schizophrenia
_____ Bipolar Disorder

Endocrine
_____ Diabetes
_____ *Type I*
_____ *Type II*
_____ Low Thyroid
_____ High Thyroid
_____ Hot Flashes
_____ Insulin Pump
_____ Goiter

Gynecologic
_____ Vaginal Bleeding
_____ Vaginal Discharge
_____ Irregular Periods
_____ Fibroid Tumors
_____ Abnormal Pap
_____ Sexually Transmitted Diseases
_____ Hysterectomy
_____ Pain With Intercourse

Autoimmune Diseases
_____ Lupus

_____ Scleroderma _____ Sarcoid _____ Rheumatoid Arthritis

QUESTION #22 FOR <u>WOMEN</u> ONLY, <u>MEN</u> SKIP TO QUESTION #23

22. What is your reproductive history?

Age of first menstrual period_____ Age when menopause began_____

Reason for menopause_____

Number of pregnancies_____ Age at first pregnancy _____

Number of miscarriages_____ Number of live births_____

Did you breast feed? ☐ No ☐ Yes (If yes, how long? _____)

Are you currently taking or have you even taken birth control drugs? ☐ No ☐ Yes

(If yes, how long? _____)

Are you currently having or have you even taken hormone replacement therapy? ☐ No ☐ Yes

(If yes, how long? _____)

23. If we are treating you for prostate cancer, please tell us about your sex life by checking one of the following.

☐ Normal male function

☐ Decrease in desire and ability to perform

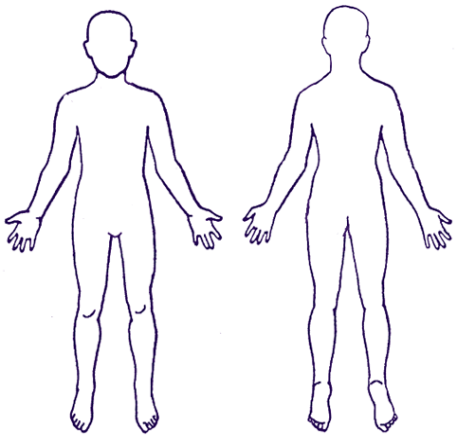
☐ Can't perform sexual relations very well (unable to maintain an erection)

☐ Can't perform sexual relations at all anymore (unable to achieve an erection)

24. Do you have any pain now? ☐ No ☐ Yes

(If yes, please indicate the location(s) of the pain on the diagram below.)

R L R L



FRONT BACK

Please describe the intensity of the pain using a scale of 0 to 10, with 10 being the most intolerable pain.

1st Site:_____Intensity (0-10):_____

2nd Site_____Intensity (0-10):_____

3rd Site_____Intensity (0-10):_____

(*see scale below for additional information)

Have you had this type of pain before? ☐ No ☐ Yes

(If yes, please answer the following questions)

How long does it last?_____

How long have you had it?_____

What causes or triggers the pain?_____

What does it feel like? _____

Wong-Baker FACES Pain Rating Scale

From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. *Used with permission. Copyright, Mosby*

The following questions will help us to determine the need for additional services:

1. **Do you have family/ friends that would be willing/ able to help you with transportation, shopping, picking up prescriptions, etc.?**_____

   _____

2. **Do You live alone**_____

   _____

3. **Do you drive? If not, do you have someone who is willing to drive you to your appointments?**

   _____

   _____

4. **Do you have a Living Will? If so, please bring a copy of your living will with you to your appointment so we can file it in your chart.**

   _____

   _____

5. **Do you have a Durable Power of Attorney? If so, please bring a copy of your Durable Power of Attorney with you to your appointment so we can file it in your chart.**

   _____

   _____

6. **Please list any family members or friends who you permit to call our office for your health information (For example, test results, appointment dates and times).**
   Please list the names, relationship and phone numbers below.

   1._____

   2._____

   3._____

   4. _____

Please sign and date your completed questionnaire below:

X_____ Date _____

REVIEWED BY: _____ Date _____

Yolanda G. Barco Oncology Staff member