**Gettysburg Cancer Center  Hanover Cancer Center**

# New Patient Information

**Full Name**: _____

**Address:** _____

**Home PH**: _____**Work PH**: _____ **Cell PH**: _____

**Contact preference *(please circle):*** Home phone  Work phone  Cell phone  **Soc. Security #** _____

**Gender *(please Circle)*:** Male / Female  **DOB:** _____ Age: _____ **Email**: _____

**Primary Language**: _____  **Ethnicity (please circle)**: Hispanic or Non-Hispanic  **RACE** _____

**Marital Status *(please circle)*:** Single  Married  Partner  Divorced  Separated  Widowed

**Employer Name:** _____ **Occupation:** _____

**Emergency Contact Name**: _____ **Relationship:** _____

**Emergency Contact PH**: _____ _____

**Pharmacy Name:** _____ **Location:** _____

**Pharmacy PH**: _____

**Who can we thank for referring you today**? _____

**Who is your family physician**? _____ **Office PH:** _____

**Do you have a living will?** YES  NO  **Do you have a durable power of attorney?** YES  NO

**Do you have a DNR order** (do not resuscitate)? YES  NO

**Medical history**:

**Do you have diabetes?** YES  NO  **Do you have high blood pressure?** YES  NO

**Have you had a heart attack?** YES  NO

**Have you had exposure to any of the following *(please circle if YES)*:** Chemicals  Asbestos  Radiation

**Do you smoke? YES  NO**  *If yes, how many years have you been smoking?* _____

*If yes, how many packs a day do you smoke?* _____

**Do you drink alcohol? YES  NO  If yes, is your drinking *mild, moderate or heavy*?** *(Please circle)*

**Work History:  Are you retired? _____  From Where? _____**

**If you are currently working, where?_____**

**What is your highest level of education? _____**

**Do you have any allergies** (medications, food, environmental)**? Please list.**

_____

**Please list any medical problems or surgeries**

_____

**Please list current medications** (prescriptions and over –the-counter)**; use the back of this form if necessary**

_____

_____

**Please indicate your hospitalization history below**:

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

******(FEMALE PATIENTS ONLY)**

**GYNECOLOGIC,** *please circle if applicable***:** **Abnormal vaginal bleeding** **Breast Biopsies** **Breast Lumps**

**AGE AT: 1ST Period:**_____ **Menopause:**_____ **1ST Pregnancy:**_____

**Date of Last: PAP:** _____ **Mammogram**_____ **Bone Density Scan:**_____

**Number of Pregnancies**_____ **Number of Live Births**_____ **Ever Use Birth Control Pills**_____

**Have you ever used hormone replacement therapy: YES NO** *(please circle)*

**FAMILY HISTORY OF MEDICAL PROBLEMS:** Please indicate number of siblings and children and their medical, cancer, or blood problems if any.

Father _____ Mother_____

Grandfather (paternal)_____Grandfather (maternal) _____

Grandmother (paternal)_____Grandmother (maternal) _____

Brother(s)_____ _____

Sister(s)_____ _____

Son(s)_____ _____

Daughter(s)_____ _____

**What is the reason for your visit today?**

_____

_____

_____

**Review of symptoms:** Please **circle** any the following you may have experienced**:**

| | | | |
|---|---|---|---|
| **Neurologic:** | Headache | Eye Problems | Weakness/TIA |
| **Head & Neck:** | Sore throat | Sinusitis | Thyroid Problems |
| **Respiratory:** | Shortness of breath | Cough | Coughing up blood or phlegm |
| | Spit blood | Asthma | Wheezing |
| **Cardiovascular:** | Chest Pain | Angina | |
| | Heart problems/Heart attacked | | |
| **Gastrointestinal:** | Indigestion | Heartburn | Constipation |
| | Diarrhea | Nausea | Vomiting |
| | Difficulty swallowing | | Change in bowel habits |
| **Genitourinary:** | Frequent Urination | Burning | Blood in Urine |
| | Change in urinary stream | | |
| **Endocrine:** | Excessive Hunger | Thirsts | |
| **Constitutional:** | Fever | | Weight loss |
| | Feeling cold or hot flashes | | Night Sweats |
| **Musculoskeletal**: | Back Pain | | Joint pain/Stiffness |
| | Body/Muscle ache | | Bone pain/Arthritis |
| | Fractures | | |
| **Psychological**: | Depression | Anxiety | Bipolar Disorder |
| | Sleep problems/insomnia | | |

## Pain:

**Where? _____ Start _____ Date_____ Rate*_____**

**(0-10 with TEN being SEVERE)*

**Additional notes to discuss with the physician**: