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: