Baylor St. Luke's Medical Center

DAN L DUNCAN COMPREHENSIVE CANCER CENTER | Baylor Medicine

7200 Cambridge St., 7th Flr.
Houston, Texas 77030
Phone: 713-798-2262

# NEW PATIENT FORMS

Date ___/___/___ Name_____Date of Birth _____

## CARE TEAM

Referring Physician_____Specialty_____Phone _____

Primary Care Physician_____Phone _____

Cardiologist_____Phone _____

## REASON FOR VISIT

_____

_____

## MEDICATION INFORMATION

| DATE STARTED | MEDICATION | DOSE (mg) | FREQUENCY | GIVEN FOR |
|---|---|---|---|---|
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |
| ___ /___/_____ | | | | |

Herbal, over-the-counter medications_____

_____

## ALLERGIES - Please list any allergies or reactions to medication(s):

_____

_____

## REVIEW OF SYSTEMS

Please CHECK if you have any of the following symptoms.

### GENERAL
- ☐ Appetite Change
- ☐ Fatigue
- ☐ Fever
- ☐ Pain
- ☐ Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other _____

### SKIN
- ☐ Cuts
- ☐ Hair Changes
- ☐ Itching
- ☐ Mass
- ☐ Mole Change
- ☐ Nail Changes
- ☐ Pallor
- ☐ Rash
- ☐ Yellowing of Skin
- ☐ Other _____

### EYE
- ☐ Discharge
- ☐ Glaucoma
- ☐ Itching
- ☐ Vision Change
- ☐ Yellowing of Eyes
- ☐ Other _____

### EARS, NOSE, MOUTH
- ☐ Change In Taste
- ☐ Dental Problems
- ☐ Dizziness
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Nose Bleed
- ☐ Ringing In Ears
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Hearing Loss
- ☐ Other _____

### LUNGS
- ☐ Chest Pain With Breathing
- ☐ Cough
- ☐ Coughing Blood
- ☐ Shortness Of Breath
- ☐ Wheezing

### HEART
- ☐ Ankle Swelling
- ☐ Blood Pressure Problems
- ☐ Chest Pain
- ☐ Fainting Episodes
- ☐ Irregular Heartbeat
- ☐ Leg Pains
- ☐ Need >1 Pillow To Sleep

### GASTRO-INTESTINAL
- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Clay-colored Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Distention
- ☐ Floating Stools
- ☐ Heart Burn
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Loose Stools
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

### GENITOURINARY
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Flank Pain
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Urgent Urination
- ☐ Urinating at Night
- ☐ Other_____

### MUSCULOSKELETAL
- ☐ Backache
- ☐ Cramps
- ☐ Muscle Ache/Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness
- ☐ Other _____

### ENDOCRINE
- ☐ Heat or Cold Intolerance
- ☐ Thirst Change

### NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Headache
- ☐ Fainting
- ☐ Memory Loss
- ☐ Numbness
- ☐ Tremors
- ☐ Weakness
- ☐ Other _____

### MENTAL HEALTH
- ☐ Alcohol or Drug Problems
- ☐ Anger Control Problems
- ☐ Personality Change
- ☐ Suicidal Thoughts
- ☐ Other _____

### MALE REPRODUCTIVE
- ☐ Sexual Difficulty
- ☐ Swelling
- ☐ Testicular Pain
- ☐ Other _____

### FEMALE REPRODUCTIVE
- ☐ Abnormal Bleeding
- ☐ Hot Flashes
- ☐ Loss of Period
- ☐ Pelvic Pain
- ☐ Sexual Difficulty
- ☐ Vaginal Dryness
- ☐ Vaginal Discharge
- ☐ Other _____

### BREASTS
- ☐ Nipple Discharge
- ☐ Mass
- ☐ Pain
- ☐ Other _____

### HEMATOLOGIC AND LYMPH SYSTEM
- ☐ Bleeding
- ☐ Bruising
- ☐ Lymph Node Swelling
- ☐ Lymph Node Tenderness
- ☐ Repeated Infections
- ☐ Other _____

## MEDICAL HISTORY

Please check the boxes to indicate if you have had any of these conditions:

- ☐ NONE
- ☐ AbnormalPap
- ☐ Allergies, Seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Blood Clots/DVT
- ☐ Carotid Artery Disease
- ☐ Cataracts
- ☐ Cancer
- ☐ Cirrhosis
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Memory Loss
- ☐ Migraine/Headaches
- ☐ Osteoporosis
- ☐ Reflux or GERD
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Ulcers of Stomach
- ☐ UTIs - Recurrent
- ☐ Valve Problem/Murmur

Please list type(s) of cancers, date(s) of diagnosis, and type(s) of treatment (surgery, chemotherapy, radiation, ect.)

_____

_____

_____

Please specify any other important medical condition(s) that you have now or had : _____

_____

_____

_____

Any prior blood transfusions? ☐ Yes ☐ N If yes, date _____

Any prior iron transfusions? ☐ Yes ☐ N If yes, date _____

Any prior Hematology visits? ☐ Yes ☐ N If yes, date _____

## SURGICAL HISTORY

Please use the space below to list your past surgical procedures.

Surgery Date

_____

_____

_____

_____

Any difficulty with anesthesia? ☐ Yes ☐ N If yes, please indicate _____

_____

## FAMILY CANCER HISTORY

Check here ☐ if you were adopted.

Do you have Ashkenazi Jewish ancestry? □ Yes □ No

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ More than one race ☐ Unknown or not reported

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

List all family members who have had cancer. Indicate an estimated **age of diagnosis** in the box. This history should include first, second and third degree relatives (children, parents, siblings, nieces, nephews, grandparents, aunts, uncles, cousins, great aunts, and great uncles from **both sides of your family**). Please indicate maternal family members with an "M" and paternal family members with a "P". Example: "M Aunt" for a maternal aunt or "P half-sister" for a paternal half-sister.

Write the estimate age of diagnosis in each box

| Family Member | Breast cancer | Ovarian cancer | Uterine/ Endometrial cancer | Pancreatic cancer | Colon cancer | Gastric cancer | Prostate cancer | Melanoma | Other Cancer (please write the type) |
|---|---|---|---|---|---|---|---|---|---|
| EXAMPLE: P Cousin | 65 | | | | | | | | Thyroid- 35 |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

## FAMILY HISTORY

Please write in any IMMEDIATE family member (i.e. mother) who has or has had any of the following conditions. Include their age when first diagnosed.

| CONDITION | RELATION? | AGE |
|---|---|---|
| Heart Attack | | |
| Mental Health | | |
| Stroke | | |
| Other | | |

## SCREENING ASSESSMENT

Indicate most recent date and result of the following

| EXAM | DATE | RESULT |
|---|---|---|
| Colonoscopy | __/__/____ | |
| Skin cancer screening | __/__/____ | |
| PSA and prostate (men) | __/__/____ | |
| Mammogram (women) | __/__/____ | |
| Pap smear (women) | __/__/____ | |

## SOCIAL HISTORY

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Religious Preference _____

Number of children_____Work status ☐ Retired ☐ Disabled ☐ Unemployed ☐ Employed

Your most recent occupation _____

Drug use? ☐ Never ☐ Former ☐ Current Was your use ☐ Chronic or ☐ Social?

If you have ever used drugs, indicate which kind, the frequency and the date you quit, if applicable.

_____

_____

### TOBACCO USE

Do you smoke? ☐ No ☐ Quit (when?_____) ☐ Yes (packs per day =_____)

Do you use smokeless tobacco? ☐ No ☐ Quit (when?_____) ☐ Yes (cans per day =_____)

How long have you used tobacco products (vaporizers, e-cigarettes, hookahs, etc)?_____yrs

Do you need help quitting? ☐ Yes ☐ No

### ALCOHOL

Do you consume alcohol? ☐ No ☐ Quit (when?_____) ☐ Yes

How many drinks* containing alcohol do you consume in a week? _____

### EXERCISE INFORMATION

Approximately how many times do you exercise per week? _____

Approximately how many hours per week? _____

What type of exercise? ☐ Moderate- Walking ☐ Vigorous- running or biking

Is there any other information we should know to assist us in caring for you?_____

_____

## PAIN ASSESSMENT

Are you having any pain? ☐ Yes ☐ No

If you are in pain, how strong is your pain? Please circle a single number.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How long have you had your pain?_____Where do you feel pain? _____

Is your pain located ☐ in one spot ☐ spread out

How does the pain feel? ☐ Aching ☐ Cramping ☐ Gnawing ☐ Heavy ☐ Hot or burning

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tender ☐ Throbbing ☐ Tiring or exhausting

Which activities make pain worse or improve it? _____

_____

Does your pain limit what you can do? ☐ Yes ☐ No

How often does the pain occur?_____How long does it last? _____

## OB/GYN AND BREAST HISTORY (FOR WOMEN ONLY)

How many pregnancies? _____ How many children have you given birth to? _____

Age at first delivery _____

Any complications during pregnancy or delivery? _____

Age of first menstrual period _____ Date of last menstrual period _____/_____/_____

How often is/was your period? _____ How many days does your period last? _____

Do you have problems with your period? _____

Have you used birth control? _____

What type(s) of birth control? _____

Date started _____ Date stopped _____ Number of years _____

Have you taken estrogen or other female hormones? ☐ Yes ☐ No

☐ Estrogen only ☐ Estrogen and Progesterone

Hormone replacement therapy Date started _____ Date Stopped _____ Number of years___

Have you breastfed any infants? ☐ Yes ☐ N If yes, indicate the combined time for all children

☐ <1 year ☐ 1-2 years ☐ 2-3 years ☐ >3years

Have you ever had a breast biopsy? ☐ Yes ☐ N If yes, indicate number of biopsies on each side.

Left_____Right _____

Date of last mammogram?_____Date of last breast ultrasound? _____