HOPE Women's Cancer Center
New Patient Intake Form

First Name:	Middle Name:	Last Name:	Date of Birth:
Date of Visit:	Reason for Visit:		

Referring Physician:	Facility:	Specialty:
Other Physician:	Facility:	Specialty:
Other Physician:	Facility:	Specialty:

Allergies: ☐ No Known Drug Allergies ☐ Yes, Drug Allergies	If YES, list here:
Are you allergic to IV Contrast or Shellfish? ☐ No ☐ Yes	If YES, last reaction:
List of other allergies:	

Preferred Pharmacy:	Phone Number:	Location:
Email Address (Optional):		
Have you served in the military? ☐ No ☐ Yes	If YES, which branch:	

Please mark any of the following illnesses:		
Heart/Vascular:	**Neurological**:	**Muscular/Skeletal**:
☐ Heart Attack	☐ Stroke	☐ Arthritis
☐ Arrhythmia	☐ Seizure	☐ Chronic Back Problems
☐ High Blood Pressure	☐ Migraine	☐ Other:
☐ High Cholesterol	☐ Other:	**Cancer**:
☐ Blood Clot	**Urinary**:	☐ Type:
☐ Bleeding Disorder	☐ Kidney Disease	☐ Year:
☐ Other:	☐ Other:	☐ Treatment:
Lungs:	**Metabolic**:	**Behavioral Health**:
☐ Asthma	☐ Diabetes	☐ Depression
☐ Emphysema/COPD	☐ Thyroid Disease	☐ Anxiety
☐ Other:	☐ Other:	☐ Bipolar Disorder
Gastrointestinal:	**Reproductive**:	☐ Other:
☐ Reflux	☐ Abnormal Pap	**Autoimmune**:
☐ Ulcers	☐ STD	☐ Rheumatoid Arthritis
☐ Liver Disease	☐ Irregular Periods	☐ Lupus
☐ Other:	☐ Infertility	☐ Fibromyalgia
	☐ Sexual Assault/Abuse	☐ HIV/AIDS
	☐ Other:	☐ Other:

Previous Surgeries	
Date:	Reason:
Date:	Reason:
Date:	Reason:
Other Hospitalizations	
Date:	Reason:
Date:	Reason:
Date:	Reason:

Age at First Menstrual Cycle:		Age at First Pregnancy:		Are you currently pregnant?	☐ No ☐ Yes
Date of Last Menstrual Cycle:		Age at Menopause:			
Prior Hysterectomy:	☐ No ☐ Yes, what age?	Were the ovaries removed?	☐ No ☐ Yes, Tubal?	☐ No ☐ Yes	
Number of Children:		Number of Pregnancies:		Number of Miscarriages:	
Number of Abortions:					

Hormone/Birth Control History:					
Number of Years Taken:		Date Stopped:		Reason:	

Check YES if you have had any of the following services:			
Pap Smear	☐ No ☐ Yes, date:	Mammogram	☐ No ☐ Yes, date:
Bone Density	☐ No ☐ Yes, date:	Colonoscopy	☐ No ☐ Yes, date:
Flu Shot	☐ No ☐ Yes, date:		

Family History							
Have any of your relatives ever had cancer? (include children, siblings, parents, grandparents, aunts, and uncles)							
Relationship:		☐ Mother's Side ☐ Father's Side	Age at Diagnosis:		Cancer Type:		
Relationship:		☐ Mother's Side ☐ Father's Side	Age at Diagnosis:		Cancer Type:		
Relationship:		☐ Mother's Side ☐ Father's Side	Age at Diagnosis:		Cancer Type:		
Relationship:		☐ Mother's Side ☐ Father's Side	Age at Diagnosis:		Cancer Type:		
Other major family illnesses (include relationship):							

Patient History					
Where were you born? (City/State):					
Occupation (Present and Former):					
Who do you go to for emotional support?					
List your children (Name and Age):					
Are you a user of tobacco?	☐ Current User ☐ Former User ☐ Never Used Tobacco ☐ Unknown				
Type:		Amount:		Years Used:	
Have you ever tried to quit?	☐ No ☐ Yes	If YES, year(s)?		Longest tobacco-free?	
Does anyone around you smoke?	☐ No ☐ Yes				
Are you a user of alcohol?	☐ Current User ☐ Former User	Type:		Amount:	
How often?	☐ Daily ☐ Weekly ☐ Monthly	When was your last drink?	☐ Last Night ☐ Last Week ☐ Last Month ☐ Last Year		

Caffeine Intake Survey					
Type:	☐ Tea ☐ Coffee ☐ Soda	Amount:		How often?	☐ Daily ☐ Weekly ☐ Monthly

Exercise Survey					
Do you exercise?	☐ Never ☐ Occasionally ☐ Regularly	Type:		Amount:	

Advanced Directives – Please bring a copy with you
☐ None ☐ Living Will ☐ DNR ☐ Power of Attorney ☐ HC Proxy

Hearing/Reading Problems:	☐ No ☐ Yes, list details:
Stressors/Concerns:	☐ Major illnesses in family ☐ Recent death of a loved one ☐ Other:

Please mark any of the following symptoms:		
Constitutional:	**Gastrointestinal**:	**Metabolic/Endocrine**:
☐ Decreased Appetite	☐ Abdominal Pain	☐ Trouble Sleeping
☐ Fatigue	☐ Constipation	**Neuro/Psychiatric**:
☐ Fever	☐ Diarrhea	☐ Dizziness
HEENT:	☐ Heartburn	☐ Headache
☐ Eye Problems	☐ Nausea	☐ Fainting
☐ Ear Problems	☐ Blood in Stool	☐ Memory or Thinking Problems
☐ Nosebleeds	☐ Vomiting	☐ Numbness
☐ Problems Swallowing	☐ Abdominal Swelling	☐ Mood Swings/Depression/Anxiety
☐ Mouth Sores	**Genitourinary**:	**Dermatologic**:
☐ Throat Sores	☐ Problems Passing Urine	☐ Itching
Respiratory:	☐ Blood in Urine	☐ Rash
☐ Cough	**Reproductive**:	**Musculoskeletal**:
☐ Problems Breathing	☐ Nipple Discharge	☐ Bone or Joint Problems
Cardiovascular:	☐ Breast Lumps	☐ Muscle Problems
☐ Chest Pain	☐ Breast Pain	**Hematologic**:
☐ Foot or Leg Swelling	☐ Vaginal Discharge	☐ Bleeding
	☐ Abnormal Vaginal Bleeding	☐ Swelling or Pain at Port/Cath
	☐ Hot Flashes	

Medication History

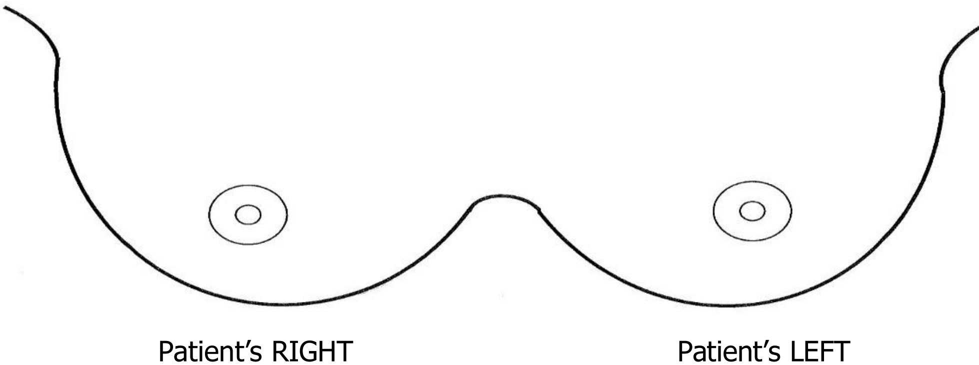
Prescription Medication:	Dose (in milligrams):	How many times per day?	Prescribing Doctor:

Over the Counter Medication:	Dose (in milligrams):	How many times per day?

For BREAST PATIENTS:

Do you examine your own breasts?	☐ No ☐ Yes	If YES, how often:				
Prior injury to either breast?	☐ No ☐ Yes	If YES, list details:				
Prior breast surgery?	☐ No ☐ Yes	If YES, what age?		Type:		Findings:
Nipple Discharge?	☐ No ☐ Yes	If YES, which side?		How long?		Color:
Breast Pain?	☐ No ☐ Yes	If YES, list details:				
Did you breast feed your children?	☐ No ☐ Yes	If YES, for how long?				

Draw a circle over the area of concern:



For clinical use

Information was entered by:		**MSJ ID:**	