Patient Packet

Forms contained:
1. Patient History
2. Medication List
3. Patient Checklist

Please complete these forms before arriving for your appointment.
Name of Patient: ___________________________ DOB ____________ Age _________

Date form completed __________ Race/Ethnicity ___________ Gender (circle) M F

Marital Status ___________ Education ___________ Primary Language ___________

Address: __________________________________________ Interpreter Needed Y or N

_________________________________________________________________________________

Home Phone: ( ) ____________________

Work Phone: ( ) ____________________

Cell/Other: ( ) ____________________

Email address ____________________

Preferred method of contact (please circle): Home___ Work ___ Cell ___ Email

Reason for visit/referral: (please indicate site, if appropriate)
_________________________________________________________________________________

_________________________________________________________________________________

Referring Physician(s) (please note if you want this individual to be informed of health related decisions and treatment plans): 

Name ___________________________________________ Send Correspondence? Y or N

Specialty ___________________________ Phone Number ( ) ____________________

Address ________________________________

City ___________________________ State _________ Zip Code ____________________

Name ___________________________________________ Send Correspondence? Y or N

Specialty ___________________________ Phone Number ( ) ____________________

Address ________________________________

City ___________________________ State _________ Zip Code ____________________
### Pregnancy History:

- Age of first pregnancy: ______
- # of pregnancies: ______

### Lactation History:

- Have you ever breast fed:  Y or N
- If yes, for how long? (total for all children, if possible): ______

### Menstrual History:

- Age of First Menstrual Period: ______
- Age at menopause: ______
- If pre-menopausal: Date of Last Menstrual Period: ______
- Are your menstrual periods regular:  Y or N
- If yes, # of days in cycle: ______

If you require a treatment that may impair your fertility, would you like information regarding the options for preserving your reproductive ability, if possible? (please circle) Y or N

### Hormone Use:

- Have you ever used hormone replacement therapy? (please circle) Y or N
- If yes, for how long: ______
- Name of medication: ______

- Are you currently taking hormone replacement? (please circle) Y or N
- If yes, for how long: ______
- Name of medication: ______

- Have you ever taken oral contraceptives? (please circle) Y or N

Are you presently bothered by symptoms related to menopause such as hot flashes? (please circle) Y or N

If you are a male have you had a PSA Test? (please circle) Y or N

If your answer is yes, what was the date of your last PSA Test? ______

**Result:** Normal (circle) Abnormal (explain): ______
Prior Hospitalizations/Medical Problems:
Have you ever been diagnosed with a tumor (benign or cancerous) previously?  Y or N

Please list all previous tumors:

<table>
<thead>
<tr>
<th>Site of tumor</th>
<th>Date of Diagnosis</th>
<th>Date of Last Treatment</th>
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Medical History: please include prescription & over the counter medications

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<th>Medication (include dose)</th>
<th>Medication (include dose)</th>
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Blood Transfusion History:
Have you ever received a blood or blood product transfusion?  Y  N
If Yes: Date_____________ Location Received (hospital name)______________

Allergies: Please list all medication and dye-related allergies.

<table>
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<tr>
<th>Medication/Food/Substance</th>
<th>Allergic Reaction</th>
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</table>
Date of Last Colonoscopy: ________________________________________________

Result: Normal (circle) Abnormal (explain):________________________________

Date of Last Pap Smear: ________________________________________________

Result: Normal (circle) Abnormal (explain): ____________________________

Date of Last Mammogram: _____________________________________________

Result: Normal (circle) Abnormal (explain): _____________________________

Breast Self Examination: Do you perform breast self-examinations? Y or N
If yes, how frequently? Monthly (circle) other (please specify) ______________

Have you ever had or do you currently have any of the following: (please check all that apply)

☐ Diabetes Mellitus(sugar) ☐ Leukemia/Lymphoma ☐ Gall Stones
☐ Hyperthyroidism ☐ Thrombocytopenia/IT ☐ Gastrointestinal Bleeding
☐ Hypothyroidism ☐ P/TTP ☐ Emphysema
☐ Goiter ☐ Tuberculosis ☐ Other____________
☐ Adrenal Problems ☐ High blood pressure ☐ Other____________
☐ Cushing’s Disease ☐ Peripheral Vascular Disease ☐ Other____________
☐ Hepatitis A, B, C ☐ Stroke or TIA ☐ Other____________
☐ Jaundice ☐ Heart Attack/Angina ☐ Other____________
☐ Liver Disease ☐ Cardiac Disease ☐ Other____________
☐ Peptic Ulcer Disease ☐ Congestive Heart Failure ☐ Other____________
☐ Gastric Reflux ☐ Pulmonary Edema ☐ Other____________
☐ Crohn’s Disease ☐ High Cholesterol ☐ Other____________
☐ Ulcerative Colitis ☐ Acute Pancreatitis ☐ Other____________
☐ HIV/AIDS ☐ Chronic Pancreatitis ☐ Kidney Stones
☐ Kidney Disease ☐ Emphysema
☐ Bleeding Disorders

Please list all previous hospitalizations (including surgery): ________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Social History:

Do you or have you ever:
Used tobacco: Y or N (please check) Cigarettes____ Cigars____ Chewing Tobacco____ Pipe____
If yes, how much and for how long? _____________________________________
Drank alcohol?    Y  or  N
Number of beers/week:  ________    # of years    ______
Number of shots/drinks of hard alcohol/week:  ______    # of years    ______
Number of glasses of wine/week:  ______    # of years    ______

Do you or have you ever used recreational drugs (cocaine, heroine, marijuana) or been addicted to prescription drugs?    Y  or  N
If yes, please describe_____________________________________________________

What is your current occupation?  __________________________________________
If not your present occupation, what is the occupation you held for the longest period of time?  _________________________________ For how long?  ____________________
To the best of your knowledge, were you ever exposed to any occupational hazards (such as asbestos, radiation, coal dust, etc.)?  ______________________________________

**Family History:**
**List all medical condition of your family members including cancer:**

<table>
<thead>
<tr>
<th>Paternal Grandfather</th>
<th>Maternal Grandfather</th>
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</thead>
<tbody>
<tr>
<td>Paternal Grandmother</td>
<td>Maternal Grandmother</td>
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<tr>
<td>Father</td>
<td>Mother</td>
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<tr>
<td>Sibling</td>
<td>Sibling</td>
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<tr>
<td>Sibling</td>
<td>Sibling</td>
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<tr>
<td>Child</td>
<td>Child</td>
</tr>
</tbody>
</table>

| Others (list):       |

**Review of Systems:**
Do you presently have any of the following (please check all that apply):

**Constitutional:**
- [ ] No concerns
- [ ] Weakness
- [ ] Fatigue
- [ ] Lack of Appetite
- [ ] Fevers
- [ ] Night Sweats
- [ ] Weight Loss
- [ ] Malaise
- [ ] Chills
- [ ] Difficulty Sleeping

**Psychological:**
- [ ] No concerns
- [ ] Depression
- [ ] Anxiety
- [ ] Agitation
- [ ] Suicidal Thoughts
- Memory
difficulty/forgetfulness

**Neurologic:**
- [ ] No concerns
- [ ] Extremity/muscular weakness
- [ ] Gait instability
- [ ] Dizziness
- [ ] Blurry vision
- [ ] Paralysis
- “Pins and Needles” (parasthesias)
- Loss of vision
- Headaches
- Double vision
- Loss of sensation
- Difficulty in speaking
- Blackouts
- Confusion/Difficulty in thinking
Endocrine:
- No concerns
- Goiter
- Heat Intolerance
- Cold Intolerance
- Weight loss
- Weight gain
- Tremors
- Change in voice
- Increase in facial/body hair (not related to menopause)
- Decrease in facial/body hair
- Change in menstrual periods/Loss of menstrual periods
- Excessive thirst
- Increased urination
- Increased appetite

Skin:
- No concerns
- Dryness of skin
- Excessive itching
- Rash (persistent)
- Change in skin color
- Changes in finger/toe nails
- Skin ulcers/bruising
- New moles/spots

Lymphatics:
- No concerns
- “Swollen nodes or glands”
- Bumps under arms, in groin or in neck
- Swelling of arms or legs

Cardiovascular:
- No concerns
- Arrhythmia or “funny heart beat”
- Chest pain
- Heart Attack
- Palpitations
- Tightness of Chest
- Shortness of breath
- Exercise intolerance
- Need to sleep on more than 1 pillow
- Calf pain with walking distances
- Swelling of the legs
- Heart Murmur
- Shortness of breath lying down/unable to lie flat

Respiratory:
- No concerns
- Dry Cough
- Productive Cough
- Coughing up Blood
- Wheezing
- Asthma
- Shortness of breath
- Pain with breathing
- Stridor
- Hay fever

Ears, Eyes and Throat:
- No concerns
- Blurred vision
- Spots in your eyes
- Pain in the eyes
- Eye infections
- Difficulty hearing
- Ringing in the ears
- Pain in the ears
- Discharge from the ears
- Nosebleeds
- Rhinorrhea (runny nose)
- Chronic stuffy nose
- Sinus trouble
- Hay fever
- Neck Pain
- Throat Pain
- Dental problems
- Oral sores
- Bleeding gums
- Decreased vision
<table>
<thead>
<tr>
<th><strong>Gastrointestinal:</strong></th>
<th>** Urinary Tract:**</th>
<th>** Genital Tract:**</th>
<th><strong>Musculoskeletal:</strong></th>
<th><strong>Medical Devices/Implants/Other:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No concerns</td>
<td>□ No concerns</td>
<td>□ No concerns</td>
<td>□ No concerns</td>
<td>□ No concerns</td>
</tr>
<tr>
<td>□ Anorexia (loss of</td>
<td>□ Constipation</td>
<td>□ Black/Tarry stools</td>
<td>□ Discharge from</td>
<td>□ Indwelling catheter</td>
</tr>
<tr>
<td>appetite)</td>
<td>□ Bloody vomiting</td>
<td>□ Stools that float/oily in appearance/foul smelling</td>
<td>□ penis</td>
<td>□ Hepatic Infusion Pump</td>
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<tr>
<td>□ Early satiety</td>
<td>□ Blood in stool</td>
<td>□ Food intolerance</td>
<td>□ Pain with intercourse</td>
<td>□ Dialysis access</td>
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<tr>
<td>□ Nausea</td>
<td>□ Pain with bowel movements</td>
<td>□ (i.e. fatty foods)</td>
<td>□ Vaginal discharge</td>
<td>□ Insulin pump</td>
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<tr>
<td>□ Vomiting</td>
<td>□ Pain with swallowing/difficult swallowing</td>
<td>□ Abdominal cramping/bloating</td>
<td>□ Pain with intercourse</td>
<td>□ Automated Intracardiac Defibrillator (AICD)</td>
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<tr>
<td>□ Jaundice</td>
<td>□ Unable to swallow foods</td>
<td></td>
<td>□ Vaginal/Labial Mass/Ulcer</td>
<td>□ Pacemaker</td>
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<tr>
<td>□ Abdominal Pain</td>
<td>□ Urinary Tract Infections</td>
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<td>□ Change in menstrual flow</td>
<td>□ VP Shunt</td>
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<td>□ Heartburn</td>
<td>□ Difficulty starting to urinate</td>
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<td></td>
<td>□ Peritoneal Dialysis Catheter</td>
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<tr>
<td>□ Reflux</td>
<td>□ Incontinence</td>
<td>□ “extra” periods/excessive bleeding</td>
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<td>□ Orthopedic implants</td>
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<tr>
<td>□ Diarrhea</td>
<td>□ Repeated Urinary Tract Infections</td>
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**For Breast Patients:** (If you have had a mastectomy, complete the following only for the existing breast, if you have had a bilateral mastectomy, please go on to the next section.)

Have you ever had a prior breast biopsy?  **Y** or **N**  
**If yes, circle type and write the number of times on the line:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Right</th>
<th>Left</th>
<th>Date</th>
<th>Hospital Performed</th>
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<tbody>
<tr>
<td>Fine Needle</td>
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<tr>
<td>Breast Lumpectomy</td>
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<tr>
<td>Core Needle Biopsy</td>
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<tr>
<td>Surgical Biopsy</td>
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**Subsequent/Other Breast Surgery:**

Have you had any other surgery on your breasts? (please circle)  **Y** or **N**  
*(If yes, please complete the section below.)*

Which of the following other procedures have you had?

<table>
<thead>
<tr>
<th>Procedure Type</th>
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<th>Hospital Performed</th>
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<td>Implants</td>
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<td>Breast Reduction</td>
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<td>Breast Reconstruction</td>
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<td>Other (please specify):</td>
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*Thank you.*
Medication List

Patient Name: ____________________  Date: ________________

Please provide a list of all the medications you take. This list must include vitamins, over-the-counter remedies, items from health food stores, and all herbal remedies. In order to help provide you with safe care, we check to make sure that there are no known interactions with cancer fighting drugs and your medications. If you are unable to make a list of the medications, bring them with you and we will write them down. You will take the medications back home with you after your appointment.

<table>
<thead>
<tr>
<th>Medication or Supplement</th>
<th>Dosage or amount taken</th>
<th>How taken</th>
<th>How often taken</th>
</tr>
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<tbody>
<tr>
<td>Example: Aspirin</td>
<td>Example: 81 mg</td>
<td>Example: by mouth</td>
<td>Example: once a day</td>
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</table>

I am allergic to the following medications:

<table>
<thead>
<tr>
<th>Medication (Example: codeine)</th>
<th>Reaction (Example: vomiting)</th>
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New Patient Checklist

Thank you for choosing Winship Cancer Institute for your healthcare. The Winship referral office obtained your medical records prior to scheduling you for your first appointment. If you think there are more recent records since that time, please bring copies with you.

The following is a list of items you need to bring with you for your first appointment.

- Insurance card
- Driver’s license or alternate photo ID
- Medication list: Please include all prescription and over-the-counter medications you are currently taking.
- X-ray films, CT, PET, and/or MRI scans (only if available)
- Pathology slides (only if available): Pathology slides are used to diagnose the type of disease you may have.

In addition to the above required items, we also suggest you bring the following with you to your appointment.

- Friend or family member: Your first appointment may be a little overwhelming. A friend or family member can help in asking your doctor all the right questions and in remembering all that is discussed during your appointment.
- Questions for your Doctor: Consider bringing your questions in a written form. This will help remember what questions you want answered. Bring a pen and notebook so you have a place to write the answer to your questions.
- Snack: You may be here a lengthy amount of time for your first appointment. A snack can help if you are hungry and can not get something to eat right away.
- Light jacket or sweater: The waiting areas and exam rooms can be cool at times.
- Reading materials

As a new patient to Winship, you will be scheduled to meet with the Financial Department approximately an hour before your first appointment with your physician. Please note that if you are scheduled to see more than one medical provider, you will be asked to provide multiple co-pays for these visits. These payments can be made by cash, check, or credit card.