

Established Patient Intake Form

ACCOUNT# _____ APPT DATE: _____ TIME: _____ PHYSICIAN: _____

Ⓡ Name of Physician who referred you here for this problem: _____ (M.D. / D.O.)

>>>That physician's phone # (_____) _____ - _____

Ⓡ Please list the reason for your evaluation today? (Chief Complaint / Symptoms)

Ⓡ Where on your body is your problem or pain located? (be specific):

Ⓡ How would you describe your problem or pain? Ache / Burn / Radiate / Tingle / Migrate / Other (please specify):

Ⓡ On a scale of 1 to 10, with 10 being the most severe how would you rate this problem or pain?
1 2 3 4 5 6 7 8 9 10or N/A

Ⓡ How long have you had this problem? ____ days ____ weeks ____ months ____ years

Ⓡ Is your problem or pain? Constant / Intermittent

Ⓡ Was there an act that brought on the problem, pain, or symptom? _____

Ⓡ Describe anything that makes the pain or problem worse:

Ⓡ Does anything make the pain or problem better?

Ⓡ Have you had any other problems, pains, or symptoms associated with this original chief complaint?

Ⓡ Have you taken any medication for your symptoms? NO / YES Did it help? NO / YES
If yes, please indicate medications: _____

Ⓡ Have you ever had surgery for this problem or a similar problem? NO / YES

*******BOXES BELOW FOR OFFICE USE ONLY*******

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My signature below verifies that the information provided on this document is accurate as of today's date; I authorize the physician to proceed with evaluation and treatment of my chief complaint:

Patient's PRINTED name: _____ Date of Birth: _____

SIGNATURE: _____

SIGNATURE OF: (PLEASE CIRCLE) Patient / Parent / Legal Guardian / Patient Advocate

Date

Review of Systems:

Please circle YES or NO for each AND indicate if CURRENT or PREVIOUS...

Constitutional:

Weight Gain YES NO amount: _____
Weight Loss YES NO amount: _____
Fever YES NO
Chills YES NO

Eyes:

Blurry Vision YES NO
Double Vision YES NO
Eye Pain YES NO

Ears, Nose, Throat:

Ear Infection YES NO
Sinus Problems YES NO
Sore Throat YES NO
Difficulty Swallowing YES NO

Cardiovascular:

High Blood Pressure YES NO
Heart Murmur YES NO
Heart Attack YES NO date _____
High Cholesterol?Lipids YES NO
Clotting Disorder YES NO
Thrombosis YES NO
Varicose Veins YES NO
Leg Swelling YES NO

Gastrointestinal:

Nausea YES NO
Vomiting YES NO
Constipation YES NO
Diarrhea YES NO
Ulcers YES NO
Change in bowel habits YES NO
Blood/Mucus in Stool YES NO
Diverticulosis YES NO
Heartburn/Reflux YES NO

Genitourinary:

Painful Urination YES NO
Urinary Frequency YES NO
Urinary Retention YES NO
Blood in Urine YES NO
Genital Disorder YES NO
Kidney Stones YES NO

Musculoskeletal:

Joint Pain YES NO
Neck Pain YES NO
Back Pain YES NO

Oncology

Chemotherapy YES NO
date(s) _____
Radiation YES NO
date(s) _____
Cancer type _____ & date _____

Integument (skin):

Skin Rash YES NO
Boils YES NO
Warts YES NO
Moles YES NO
Persistent Itching YES NO

Neurological:

Tremors YES NO
Dizzy Spells YES NO
Numbness: _____ YES NO
Tingling: _____ YES NO
Seizure YES NO date _____
Stroke YES NO date _____
Nerve Loss: _____ YES NO

Respiratory:

Asthma YES NO
Bronchitis YES NO
Pneumonia YES NO
Emphysema YES NO
Persistent Cough YES NO
Sleep Apnea YES NO

Endocrine:

Excessive Thirst YES NO
Hot or Cold Spells YES NO
Tired YES NO
Sluggish YES NO
Diabetes YES NO
Obesity YES NO
Thyroid Disease YES NO
Parathyroid Disease YES NO

Lymphatic:

Swollen Glands YES NO
Blood Clotting YES NO date _____

Hematologic:

Anemia YES NO
Bleeding Disorder YES NO
Hepatitis A – B – C YES NO
HIV – AIDS YES NO

Psychological:

Bi-Polar YES NO
Depression YES NO
Drug Addiction YES NO

OTHER:

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Date

****Please indicate any testing that you have had done for your CHIEF COMPLAINT****

<i>TEST / EXAMINATION</i>	<i>WHERE IT WAS PERFORMED</i>	<i>WHEN / DATE</i>	<i>Office Use ONLY Initial if reviewed</i>
Blood / Lab Studies			
X-rays; GI Studies			
CT Scan			
MRI			
Pet CT Scan			
Ultrasonography			
Mammography			
Colonoscopy			
EGD			
HIDA Scan			
Bone Scan			
<i>BIOPSY</i>			
<i>SURGERY</i>			
<i>OTHER</i>			
<i>OTHER</i>			

***** ALL TEST RESULTS / MEDICAL RECORDS MUST BE FORWARDED TO OUR OFFICE BEFORE WE MAY CONFIRM ANY APPOINTMENT IN OUR OFFICE.**

*****IMPORTANT: OUR NURSING STAFF WILL DOCUMENT YOUR MEDICATIONS – as they may be relevant when considering surgery. ***PLEASE BE SURE TO COMPLETE OUR MEDICATION FORM, AS PROVIDED.**

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Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? YES NO

Have you ever been diagnosed with cancer? What site: _____ Age: _____

COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)			Self, Sibling or Child	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50			Aunt-colon Sister-uterine	47 yrs 60 yrs
Y	N	Have YOU been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family with any of the following, one diagnosed before 50 (please circle): colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	Three or more relatives on the same side of the family with any of the following diagnosed at any age (please circle): colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	Family member has a known Lynch syndrome mutation *if you are unfamiliar with Lynch syndrome it is unlikely that it exists in your family				
BREAST AND OVARIAN CANCER (HBOC/BRCAAnalysis)			Self, Sibling or Child	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family at any age				
Y	N	Anyone with Triple Negative breast cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with a known BRCA mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age): _____

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SIGNATURE OF: **(PLEASE CIRCLE)** Patient / Parent / Legal Guardian / Patient Advocate Date

Please list any updates to your medical / surgical / social history since your last visit.

PHYSICIAN Signature: _____ **D.O.**
Signature above confirms that all 5 pages of this document have been reviewed with the patient and confirmed by the signed

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