Northeast Surgical Group, P.C.

New 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 10 ……..or 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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****Please indicate any testing that you have had done for your CHIEF COMPLAINT****

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

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

Diagnosis	DATE		*Diagnosis*	DATE

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Please list all surgeries you have had along with the APPROXIMATE date they were performed:

SURGERY / PROCEDURE	DATE		*SURGERY / PROCEDURE*	DATE

***IMPORTANT: OUR NURSING STAFF WILL DOCUMENT YOUR MEDICATIONS – as they may be relevant when considering surgery.

***PLEASE COMPLETE OUR MEDICATION FORM, AS PROVIDED.

We order most prescription medications, electronically. Please provide your pharmacy of choice for any prescription medications we may need to order for you:

Retail Pharmacy Name: _____ Phone # (_____) _____-_____
Pharmacy address: _____

Mail-Order Pharmacy Name: _____ Phone # (_____) _____-_____
Pharmacy address: _____

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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? No YES = What site: at what 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/BRACAnalysis)	**Self, Sibling or Child**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
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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SOCIAL HISTORY – LIFETIME

TOBACCO USE: YES NO

If yes, please indicate: CIGARETTE / CIGAR / PIPE / CHEW

AMOUNT / FREQUENCY:

_____

WHEN DID YOU START? _____

WHEN DID YOU QUIT? _____

_____

ALCOHOL USE: YES NO

…If YES, please indicate what is typical for you:

# of drinks _____ / DAY / WEEK / MONTH / YEAR

…What type of alcohol?

BEER / WINE / LIQUOR

Have you recently quit drinking? **YES NO**

If yes, when did you quit? _____

_____

MARIJUANA USE: YES NO

AMOUNT / FREQUENCY:

_____

_____

OTHER / "STREET DRUGS": YES NO

TYPE: _____

Amount / Frequency:_____

Allergies / Reactions

to medication or products?

NAME OF MEDICATION or PRODUCT	**REACTION**
ALLERGY TO LATEX?	
ALLERGY TO IODINE?	

Pregnancy / Childbirth

Are you ***pregnant*****? YES NO**

If yes, how many weeks along are you? _____

Post-partum? YES NO

If yes, Date of delivery? _____

vaginal or c-section (circle)

BLOOD TRANSFUSION PROTOCOL

Do you have a **religious** OR **personal** belief that prevents you from receiving blood or blood products? **YES NO**

PHYSICIAN *Signature*:_____D.O.

Signature above confirms that all 6 pages of this document have been reviewed with the patient and confirmed by the signed

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