



PATIENT INTAKE INFORMATION

Patient Name: _____ DOB: _____ Date: _____

Reason for Visit: _____

How did you hear about us? _____

Circle if you have ever had any of these medical conditions:

- | | | |
|---------------------------|--------------------|----------------------|
| Stroke(s) | Seizure(s) | Heart Attack(s) |
| Congestive Heart Failure | Hypertension | Irregular Heart Beat |
| COPD/Bronchitis/Emphysema | Thyroid Disease | Cataract(s) |
| Diabetes | Kidney Disease | Ulcer/Reflux Disease |
| Crohn's Disease | Ulcerative Colitis | Asthma |

List prior surgeries:

List Current Medications:

List Any Allergies: _____

(over)

Marital Status: _____ Number of Children: _____ Ages: _____

Occupation: _____ Have you ever smoked? Yes No # Years _____ Quit _____

List 1st and 2nd degree relatives with cancer or blood disorder:

<u>Relative</u>	<u>Cancer Type</u>	<u>Age at Diagnosis</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

In the last 3 to 6 months have you experienced any of these symptoms? Please check:

- | | | |
|------------------------|-----------------------------------|----------------------------------|
| _____ Fatigue | _____ Slurred Speech | _____ Nausea |
| _____ Weakness | _____ Sores in the Mouth | _____ Vomiting |
| _____ Poor Appetite | _____ Trouble Swallowing | _____ Bloating |
| _____ Weight Loss | _____ Changes in the voice | _____ Pain in Abdomen |
| _____ Fever | _____ Worsening trouble breathing | _____ Blood in Stool |
| _____ Chills | _____ Nagging Cough | _____ Black Stools |
| _____ Night Sweats | _____ Pain in Chest | _____ Blood in Urine |
| _____ Severe Headaches | _____ Fluttering of Heart | _____ Urinary Incontinence |
| _____ Double Vision | _____ Light Headedness | _____ Irregular Vaginal Bleeding |

Last Mammogram _____

Last PSA _____

Last Pelvic Exam _____

Last Colonoscopy _____