Baptist MD Anderson Cancer Center Patient Intake Form

Patient Name: _____ DOB: _____

Date: _____ Time: _____

PREFERRED LANGUAGE FOR DISCUSSING HEALTHCARE

- ☐ English
- ☐ Afrikaans
- ☐ American Sign Language
- ☐ Albanian
- ☐ Arabic
- ☐ Bengali
- ☐ Berber
- ☐ Bosnian
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Creole
- ☐ Croatian
- ☐ Czech
- ☐ Dutch
- ☐ Farsi
- ☐ Filipino
- ☐ Finnish
- ☐ French
- ☐ German
- ☐ Gujarati
- ☐ Haitian
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Karen
- ☐ Kinyarwanda
- ☐ Kirundi
- ☐ Korean
- ☐ Mandarin
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russian
- ☐ Serbian
- ☐ Spanish
- ☐ Swahili
- ☐ Tagalog
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Patient declines to specify
- ☐ Other: _____

DO YOU HAVE COMMUNICATION NEEDS ASSOCIATED WITH THE FOLLOWING?

- ☐ Language
- ☐ Hearing
- ☐ Speech
- ☐ Sight
- ☐ Ability to read/write

DO YOU REQUIRE AN INTERPRETER?

- ☐ Interpreter, Person
- ☐ Interpreter, Phone
- ☐ No/Not Needed

GENERAL INFORMATION

Please describe your reason for visit in your own words:

_____

_____

_____

_____

PREFERRED NAME: _____

PREFERRED CONTACT PHONE NUMBER: _____

MAY LEAVE MESSAGES AT PREFERRED NUMBER: (Y/N) _____

PREFERRED METHOD OF CONTACT

- ☐ Phone
- ☐ Email
- ☐ Mail

BAPTIST MD Anderson ~~Cancer~~ Center
Jacksonville, FL

PATIENT INTAKE FORM

8210

PATIENT LABEL

HOW WILL YOU GET TO YOUR APPOINTMENT?

- ☐ Drive self
- ☐ Family member
- ☐ Other _____

LIVING SITUATION:

- ☐ Lives alone
- ☐ Lives with family
- ☐ Do Not Have A Home
- ☐ Assisted living facility
- ☐ Nursing facility
- ☐ Home health care

DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING:

- ☐ Eating/drinking
- ☐ Bathing/hygiene
- ☐ Housework
- ☐ Driving
- ☐ Meal preparation
- ☐ Medications

Have you been admitted to the hospital in the last 30 days:

- ☐ Yes (If yes, name of hospital: _____
- ☐ No

Outside Referring Provider: _____

Outside Referring Specialty: _____

Other Specialists Involved in Patient's Care

Name of Treating Physician/Provider	Specialty	Reason for Seeing Physician

MEDICAL DEVICES

- ☐ None
- ☐ AV Shunt
- ☐ Blood filtering, blocking device
- ☐ Contraception Device
- ☐ Heart Mechanical Device
- ☐ Home CPAP/BiPAP machine
- ☐ Implantable Cardioverter - Defibrillator
- ☐ Implantable pump
- ☐ Implantable pain pump
- ☐ Implants - Specify _____
- ☐ Insulin pump
- ☐ Intravascular device
- ☐ Medication pump – specify: _____
- ☐ Omaya Reservoir
- ☐ Orthopedic hardware
- ☐ Orthopedic Prosthesis
- ☐ Pacemaker
- ☐ Penile Implant
- ☐ Stents
- ☐ Stimulator
- ☐ Other _____

PLEASE SPECIFY EXPOSURE TO HAZARDOUS MATERIALS AS A RESULT OF YOUR WORK OR LIVING CONDITION?

ALLERGIES:

NAME OF ALLERGEN	REACTION	DATE OF ONSET IF KNOWN	DATE OF LAST REACTION

HOME MEDICATION LIST:

NAME OF MEDICATION	DOSE	HOW FREQUENTLY	LAST DOSE TAKEN

FAMILY HISTORY (Please check if yes and indicate age of onset, if known)

DISEASE/CONDITION	MOTHER	FATHER	SISTER	BROTHER
Bladder Cancer				
Brain Tumor				
Breast Cancer				
Bronchus Cancer				
Cervical Cancer				
Colon Cancer				
Endometrial Cancer				
Kidney Cancer				

DISEASE/CONDITION	MOTHER	FATHER	SISTER	BROTHER
Leukemia				
Lung Cancer				
Melanoma				
Multiple Myeloma				
Non-Hodgkin Lymphoma				
Ovarian Cancer				
Pancreatic Cancer				
Prostate Cancer				
Renal Cancer				
Thyroid Cancer				
Other:				

PERSONAL MEDICAL HISTORY – PLEASE CHECK ALL THAT APPLY

☐ No chronic problem

GENERAL

☐ Chills
☐ Fever
☐ Night sweats
☐ Excessive sweating
☐ Recent weight gain _____ lbs
☐ Increased appetite
☐ What is your normal weight? _____ lbs
☐ Other: _____
☐ Recent weight loss _____ lbs
☐ Decreased appetite
☐ How much weight have you lost in the past three months: _____ lbs

HEAD, EYES, EARS, NOSE, THROAT

☐ Blindness
☐ Eye pain
☐ History of Retinal Detachment
☐ Ringing in the ear (tinnitus)
☐ Bleeding gums
☐ Neck mass
☐ Sores in mouth
☐ Head injury
☐ Blurred vision
☐ Glaucoma
☐ Discharge from Ear
☐ Sinus problems
☐ Difficulty swallowing
☐ Painful swallowing
☐ Sore throat
☐ Other _____
☐ Double vision
☐ History of Cataracts
☐ Ear infection
☐ Frequent Nose Bleeds
☐ Hoarseness
☐ Snoring
☐ Concussion

GASTROINTESTINAL

☐ Abdominal Pain
☐ Blood present in stool
☐ Celiac Disease
☐ Diverticulosis
☐ Hepatitis
☐ Jaundice
☐ Ostomy History
☐ Ulcer Disease
☐ Other: _____
☐ Black tarry stool
☐ Blood present when vomiting
☐ Crohn's Disease
☐ Gallbladder Disease (cholelithiasis)
☐ Hemorrhoids
☐ Liver Disease
☐ Pancreatitis
☐ Unintentional weight loss
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ GI Bleed
☐ History of Irritable Bowel
☐ Nausea/Vomiting
☐ Reflux Disease
☐ Unintentional weight gain

INTEGUMENTARY (SKIN)

- ☐ Boils
- ☐ Itching
- ☐ Lupus
- ☐ Psoriasis
- ☐ Rash
- ☐ Recent change in mole appearance
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Back Injury/Problems
- ☐ Gout
- ☐ Joint pain – specify location: _____
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Rheumatoid Arthritis
- ☐ Other: _____
- ☐ Osteoporosis

ENDOCRINE

- ☐ Cold/heat intolerance
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Hypoglycemia
- ☐ Sexual dysfunction
- ☐ Thyroid Disease
- ☐ Tired/Sluggish
- ☐ Other: _____

CARDIOVASCULAR

- ☐ Aortic Aneurysm
- ☐ Chest Pain/Angina
- ☐ Coronary Heart Disease
- ☐ Difficulty breathing on exertion
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Heart Attack (Myocardial Infarction)
- ☐ Irregular Heart Beat/Rhythm
- ☐ Mitral Valve Prolapse
- ☐ Palpitations
- ☐ Peripheral Artery Disease
- ☐ Poor Circulation
- ☐ Other heart valve conditions
- ☐ Other: _____

BREAST

- ☐ Breast Mass/Lump
- ☐ Breast Tenderness
- ☐ Nipple Discharge
- ☐ Skin Change
- ☐ Swelling Under Arm
- ☐ Other: _____

GENITOURINARY

- ☐ Breast Mass/Lump
- ☐ Breast Tenderness
- ☐ Dialysis
- ☐ Frequent Urinary Tract Infection
- ☐ Genitourinary Abnormal Bleeding
- ☐ Hematuria (Blood in urine)
- ☐ Hesitancy
- ☐ Impotence
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Night time urination
- ☐ Nipple Discharge
- ☐ Renal Stent
- ☐ Sexually Transmitted Disease
- ☐ Urethral Discharge
- ☐ Urinary Incontinence
- ☐ Urinary retention
- ☐ Urinary urgency
- ☐ Urostomy History
- ☐ Other: _____

HEMATOLOGIC

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood clotting disorders
- ☐ DVT (deep vein thrombosis)
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Reaction to blood transfusion
- ☐ Sickle Cell Anemia
- ☐ Swollen glands
- ☐ Varicose veins
- ☐ Other: _____

IMMUNOLOGIC

☐ Autoimmune disease ☐ Immunosuppression ☐ HIV
☐ Other: _____

NEUROLOGICAL

☐ Frequent Headaches
Date of Last
Headache: _____
Location of
Headache: _____
☐ Dizziness
☐ History of Epilepsy
☐ History of Migraines
☐ History of TIA/Stroke
☐ Fainting
☐ Tremors
☐ Other: _____
☐ History of Seizures
Date of Last Seizure: _____
Frequency of Seizures: _____
☐ Anticonvulsant
☐ No Anticonvulsant
☐ Numbness/Tingling

PSYCHIATRIC

☐ Anxiety/Panic Attacks ☐ Eating Disorder (Bulimia/Anorexia) ☐ History of Depression
☐ Schizophrenia ☐ Other: _____

ONCOLOGIC

TYPE OF CANCER	WHEN DIAGNOSED	TREATMENT	WHERE TREATED

RESPIRATORY

☐ Asthma ☐ Chronic/persistent cough ☐ COPD
☐ Emphysema ☐ Frequent Bronchitis ☐ Hemoptysis (coughing up blood)
☐ History of Pulmonary Embolism ☐ History of Tuberculosis ☐ Pneumonia
☐ Shortness of Breath ☐ Sleep Apnea ☐ Wheezing
☐ Other: _____

OTHER – PLEASE DESCRIBE:

_____
_____
_____
_____
_____
_____
_____

PROCEDURE/SURGERY HISTORY

NAME OF SURGERY OR PROCEDURE – INCLUDE WHICH SIDE IF APPLICABLE (I.E. LEFT BREAST MASTECTOMY)	DATE OF SURGERY

HISTORY OF FALL IN LAST 3 MONTHS: (YES/NO) _____ If yes, date of last fall: _____

USE OF AMBULATORY AID

☐ Furniture ☐ Crutches, cane, walker ☐ None, bedrest, wheelchair, nurse

SOCIAL HISTORY

HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

☐ Never
☐ Monthly or less
☐ 2-4 Times a month
☐ 2-3 Times a week
☐ 4 or more times a week
☐ Unable to obtain

HOW MANY DRINKS DO YOU HAVE ON A TYPICAL DAY?

☐ None
☐ 1 or 2 per day
☐ 3 or 4 per day
☐ 5 or 6 per day
☐ 7 or 9 per day
☐ 10 or more per day

HOW OFTEN DID YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?

☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFETIME PLEASE ANSWER BELOW:

Tobacco use within the last 14 days
When I was smoking, on average, I smoked about _____ packs of cigarettes per day
I began smoking when I was _____ years old
I quit smoking when I was _____ years old
OR with respect to today's visit _____ months / weeks / days ago
OR on the following date _____ month / day / year

TOBACCO USE WITHIN THE PAST 30 DAYS

☐ No tobacco use of any form
☐ 4 or less cigarettes a day
☐ 5 or more cigarettes a day
☐ Cigarettes but not daily
☐ Pipe or cigar daily
☐ Pipes or cigars but not daily
☐ Refused tobacco use screen
☐ Smokeless tobacco products used

CURRENT CIGARETTE USE

☐ Never smoked
☐ Former smoker
☐ Current every day smoker
☐ Current some day smoker
☐ Smoker, current status unknown
☐ Light tobacco smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked

WOMEN	MEN
☐ PREGNANT	☐ Prostate Problems
Gestational age:	☐ Testicular Pain
Estimated date of conception:	☐ Scrotal Mass
☐ PRIOR PREGNANCIES	☐ Scrotal Tenderness
Number of pregnancies:	
Number of deliveries:	
Number of miscarriages:	
Number of living children:	
Age of first pregnancy:	
☐ HYSTERECTOMY (Please record date in surgery history)	
AGE OF FIRST PERIOD:	
☐ STILL MENSTRUATING	
Date of last period: _____	
Number of days menstrual flow:	
Average number of days between periods:	
MENSTRUAL FLOW AMOUNT	
☐ Scanty	
☐ Regular	
☐ Heavy	
☐ Other:	
MENSTRUAL FLOW PATTERN	
☐ Regular	
☐ Irregular	
☐ Other	
MENSTRUATION CONCERNS	
☐ Bleeding between periods	
☐ Missing work due to cramps	
☐ Going to bed due to cramps	
☐ Other:	
☐ VAGINAL DISCHARGE	

☐ HISTORY OF RADIATION TREATMENT

Radiation type if known: _____

Radiation site: _____

Last date of radiation treatment: _____

Place of radiation treatment: _____

Name of treating physician: _____

Patient Signature: _____ Date: _____ Time: _____

Printed Name: _____