New Patient & Family History

Today's Date:_____ Patient Name:_____ (Last / First / Middle or Maiden) Date of Birth:_____

Age:____ Gender: ☐Male ☐Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other:_____

Home Address: _____ (Address / City / State / Zip Code)

Telephone (1st call):_____ Telephone (2nd call):_____

Referring Physician: _____ (Address / City / State / Zip Code)

Primary Care Physician: _____ (Name / Address / City / State / Zip Code)

Number of Children:_____ Ages:_____

What is your primary language? _____

Who lives with you? (Please check all that apply) ☐ I live alone ☐Spouse ☐Children ☐Parents ☐Friend ☐Other:_____

Who helps at home?_____

Person(s) with your Medical Record Access: _____ (Name / Relationship / Telephone)

Have you executed Medical Power of Attorney, Directive to Physicians (Living Will) or Out-of-Hospital Do Not Resuscitate forms? ☐Yes ☐No

Would you like to learn about our Advance Care Planning Program, My Choices, My Wishes? ☐Yes ☐No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? ☐Yes ☐No

I am currently: Working: ☐Yes ☐No Work Schedule is: ☐Full-time ☐Part-time ☐Sick Leave ☐Retired ☐Disability

What type of work do you currently do or have done?_____

Do you use any of the following? (Please check all that apply)

Alcohol: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine: ☐ Yes ☐ No What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Sunscreen: ☐Yes ☐No

How much time do you spend exercising each week?_____ What type of exercise?_____

Do you need to use any of the following? (Please check all that apply) ☐Cane ☐Walker ☐Wheelchair ☐Oxygen

☐Other:_____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: ☐Skin ☐Mole ☐Other:_____

Female: Breast ☐Yes ☐No Have you ever been trained properly for breast self-exam? ☐Yes ☐No

Male: Testicles ☐Yes ☐No Have you ever been trained properly for testicular self-exam? ☐Yes ☐No

Are you diabetic? ☐Yes ☐No If yes, what type:_____

If yes, how is it controlled: ☐Diet ☐Oral Medications ☐Insulin ☐Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): ☐Yes ☐No If yes, how is it controlled:_____

Reproductive History:

Female: Number of pregnancies:_____ Number of children:_____ Age at first pregnancy:_____

Did you breast feed: ☐Yes ☐No If yes, how many months (approximate): _____

Age at first period:_____ Age at menopause:_____ Age at last period:_____

Hysterectomy: ☐Yes ☐No Ovaries intact: ☐Yes ☐No If *no*, please explain:_____

Hormone use: ☐Yes ☐No Sex Drive: ☐Yes ☐No Method of birth control:_____

Male: Impotence (Erectile Dysfunction): ☐ Yes ☐No Sex Drive: ☐Yes ☐No

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

New Patient & Family History

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Last First Middle or Maiden

What is your understanding of why you are being seen:_____

_____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months:_____

_____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female:
Last mammogram: _____
Last pap smear: _____
Last colonoscopy: _____
Last bone density scan: _____
Last pneumonia vaccine: _____
Last flu vaccine: _____

Male:
Last colonoscopy: _____
Last prostate exam: _____
Last PSA screening: _____
Last pneumonia vaccine: _____
Last flu vaccine: _____

COVID-19 Vaccine:
1st Dose Date: _____ ☐Moderna ☐Pfizer ☐Johnson & Johnson
2nd Dose Date: _____ ☐Moderna ☐Pfizer ☐Johnson & Johnson
Booster Date: _____ ☐Moderna ☐Pfizer ☐Johnson & Johnson

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal **(P) = Paternal** (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	☐ Living ☐ Deceased		Grandmother (P)	☐ Living ☐ Deceased	
Father	☐ Living ☐ Deceased		Grandfather (P)	☐ Living ☐ Deceased	
Children	☐ Living ☐ Deceased		Aunt(s)	☐ Living ☐ Deceased	
Brother(s)	☐ Living ☐ Deceased		Uncle(s)	☐ Living ☐ Deceased	
Sister(s)	☐ Living ☐ Deceased		Cousin(s)	☐ Living ☐ Deceased	
Grandmother (M)	☐ Living ☐ Deceased		Other:		
Grandfather (M)	☐ Living ☐ Deceased		Other:		

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship:_____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

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