Donayre Cancer Care Center
of Columbus Regional Healthcare System

AFFILIATED WITH

Carolinas HealthCare System
Levine Cancer Institute

NEW PATIENT EVALUATION FORM

Today's Date: _____Patient's Name: _____

Date of Birth: _____ Home Address: _____

Height: _____Weight:_____Home Phone: _____ Work Phone: _____

Occupation: _____ Place of Work: _____

Emergency Contact: _____Emergency Contact Phone: _____

Referring Physician: _____ Would you like correspondence sent? □ Yes □ No

Family Physician: _____ Would you like correspondence sent? □ Yes □ No

Surgeon: _____ would you like correspondence sent? □ Yes □ No

Please list any other provider you would like correspondence sent to: _____

MEDICAL HISTORY Pharmacy: _____Phone Number: _____

Medications currently taking:

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency

Allergies to Food or Medication: _____

What Happens? _____

In your own words, what is the reason you are here today? _____

PREVIOUS CANCER TREATMENTS:

Type of Cancer: _____

Medical Center where you were treated: _____

Radiation: □ Yes □ No If yes, where? _____

Chemotherapy: □ Yes □ No If yes, what type? _____

IMMUNIZATIONS:

□ Tetanus (Year_____) □ Hepatitis B (Year_____) □ Pneumonia (Year_____)

□ MMR (Year_____) □ HIB (Year_____) □ Polio (Year_____) □ Flu Vaccine (Year_____)

MEDICAL HISTORY

Past illnesses or chronic medical problems:

	Year		Year		Year
Migraines/Headaches		Cirrhosis		High Blood Pressure	
Hearing Problems		Gallstones		Heart Attack	
Glaucoma/Cataracts		Ulcerative Colitis		Heart Disease	
Seizures/Convulsions		Hemorrhoids		High Cholesterol	
Multiple Sclerosis		Pancreatitis		Murmur	
Stroke		Kidney Failure		Chest Pain (Angina)	
Depression		Goiter		Congestive Heart Failure	
Stomach Ulcers		Diabetes		Shingles	
Hiatal Hernia		Peripheral Neuropathies		Genital Warts	
Heartburn/Reflux		Lupus/Scleroderma		Chicken Pox	
Abnormal Mammogram		Thyroid Problems		STD	
Breast Disorder		Asthma		HIV	
Abnormal Pap		Emphysema/COPD		Blood Clots	
Enlarged Prostate		Pneumonia		Bleeding Problems	
Irritable Bowel Syndrome		Tuberculosis or +PPD		Arthritis	
Crohn's Disease		Anemia		Other	
Polyps		Kidney Disease		Other	
Diverticulitis		Kidney Stones		Other	
Hepatitis/Jaundice		Urinary Frequency		Other	

PAST SURGERY:

Type	Date	Hospital

FAMILY HISTORY:

Relation	Age(s)	Medical Problems	If decreased, age/cause of death
Father			
Mother			
Brothers: #			
Sisters: #			
Children: #			

Other Relatives with cancer / type of cancer / age of diagnosis: _____

_____

Have you been around harsh chemicals or radiation? _____

What? _____Why? _____

Have you ever served in the military? _____

Females: Age your period started: _____Age your period stopped: _____

Painful periods? □ Yes □ No Regular periods? □ Yes □ No

Number of pregnancies: _____ Number of miscarriages/abortions: _____

Age at first pregnancy: _____Did you breast feed your children? □ Yes □ No

Ever used birth control pills? □ Yes □ No What type?:_____How Long?_____

Ever used hormone replacement therapy? □ Yes □ No

What type? _____Date of your last colonoscopy? _____

Date of your last pap smear? _____

Males: Date of your last prostate check? _____ Date of your last colonoscopy? _____

SOCIAL HISTORY:

Tobacco Use

Type: _____How much per day: _____How many years: _____Have you tried to quit? When? _____

Alcohol Use

Type: _____How much_____Type_____How much_____

What grade did you complete in school? _____

What language(s) do you speak? □ English Other: _____

What language(s) do you read? □ English Other: _____

Do you read? □ Yes □ No

How do you learn best? □ Video Tapes □ Audio Tapes □ Pamphlets/Books □ Questions/Answers □ Formal Classes □ Support Groups □ Other: _____

Occupation (if retired, former occupation):_____

Marital Status: □ Single □ Widowed □ Married □ Divorced

Living Situation: □ Live Alone □ Live with Other □ Family/Friend support nearby

Do you have problems getting to appointments? _____

What type of problems? _____

Do you have problems affording your medications? □ Yes □ No

Which ones? _____

Do you have financial concerns? _____

Religion: _____

Are there any religious or spiritual issues which may have an impact on your care: _____?

_____

Do you have a living will? □ Yes □ No Would you like information about one? □ Yes □ No

Is there an identified Power of Attorney? □ Yes □ No

How were you referred to our clinic? _____

This information has been reviewed with the patient.

_____ _____

Signature of Nurse Signature of Provider