MINNESOTA ONCOLOGY

NEW PATIENT INFORMATION

FULL NAME_____ **BIRTHDATE**_____

TELEPHONE: HOME _____ CELL_____ WORK_____OTHER _____

PREFERRED NAME_____ NAME OF SIGNIFICANT OTHER _____

PRIMARY DOCTOR_____ REFERRING DOCTOR_____

OTHER DOCTORS _____

PREFERRED PHARMACY_____MAIL ORDER _____

LOCATION _____

WHY ARE YOU HERE TODAY? _____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ABNORMAL BLEEDING
- ☐ CANCER (WHERE)_____
- ☐ CHICKEN POX
- ☐ COLITIS/DIVERTICULOSIS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ ENDOMETRIOSIS
- ☐ FIBROMYALGIA
- ☐ FIBROIDS
- ☐ GALL BLADDER ATTACKS
- ☐ GOUT
- ☐ GLAUCOMA
- ☐ HEART ATTACK
- ☐ HIV/AIDS
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HEPATITIS
- ☐ INFERTILITY
- ☐ IRREGULAR HEARTBEAT
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ KIDNEY DISEASE/STONES
- ☐ OVARIAN CYSTS
- ☐ PHLEBITIS/BLOOD CLOTS
- ☐ PNEUMONIA
- ☐ SEIZURES/EPILEPSY
- ☐ SHINGLES
- ☐ SKIN DISEASE/RASHES
- ☐ STD/PID
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ TOXIC CHEMICAL EXPOSURE AGENT_____
- ☐ TUBERCULOSIS
- ☐ ULCERS/GASTRITIS
- ☐ URINARY PROBLEMS OR PELVIC PROLAPSE

COMMENTS / OTHER: _____

_____

_____

_____

ANY TESTING ALREADY DONE FOR YOUR PROBLEM/DIAGNOSIS? ☐ **YES** ☐ **NO** **IF YES:**

ULTRASOUND DATE_____ LOCATION_____ MRI DATE_____ LOCATION_____

CT SCAN DATE_____ LOCATION_____ BLOOD TEST DATE_____ LOCATION_____

NAME:_____

DATE OF BIRTH:_____

PREVIOUS CANCER TREATMENTS? ☐ **YES** ☐ **NO** DESCRIBE: _____

IMMUNIZATIONS CURRENT ☐ **YES** ☐ **NO** LAST FLU SHOT_____ PNEUMONIA SHOT _____

COVID VACCINE_____ PROSTHETIC DEVICES/IMPLANTS? ☐ **YES** ☐ **NO** TYPE:_____

OPERATIONS & HOSPITALIZATIONS: PLEASE INCLUDE BIOPSIES, ENDOSCOPY, PROCEDURES (SUCH AS, BREAST BIOPSY, COLONOSCOPY)

_____ YEAR_____

_____ YEAR_____

_____ YEAR_____

_____ YEAR_____

FEMALES:

AGE OF 1ST MENSTRUAL PERIOD_____ 1ST LIVE BIRTH_____ # VAGINAL DELIVERIES_____ C-SECTIONS_____

NUMBER OF PREGNANCIES_____ LIVE BIRTHS_____ MISCARRIAGES_____ LAST MAMMOGRAM_____

HORMONE REPLACEMENTS_____ LAST PAP SMEAR_____ ABNORMAL PAP ☐ **YES** ☐ **NO**

LAST MESTRUAL PERIOD_____ PERIODS ☐ REGULAR ☐ IRREGULAR LENGTH_____ DAYS BETWEEN_____

IF STILL MENSTRUATING: PREGNANT ☐ **YES** ☐ **NO** BREASTFEEDING ☐ **YES** ☐ **NO**

BREAST: INFECTION/ABSCESS (MASTITIS) ☐ **YES** ☐ **NO** REDUCTION ☐ **YES** ☐ **NO** IMPLANTS ☐ **YES** ☐ **NO**

RADIATION EXPOSURE ☐ **YES** ☐ **NO** EVER USED IUD ☐ **YES** ☐ **NO** CYST ASPIRATION ☐ **YES** ☐ **NO**

IF YES, YEAR(S) AND RESULT: _____

MALES: LAST PROSTATE EXAM _____ LAST PSA TEST _____

SOCIAL HISTORY

MARITAL STATUS: (OPTIONAL) ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ OTHER _____

OCCUPATION_____ ☐ RETIRED ☐ UNEMPLOYED

CURRENTLY LIVE: (PLEASE CHECK) ☐ HOUSE ☐ APARTMENT ☐ NURSING HOME ☐ OTHER_____

WHAT TOBACCO PRODUCTS HAVE YOU EVER USED? _____

IF CIGARETTES, HOW MANY PACKS PER DAY?_____FOR HOW MANY YEARS? _____

DO YOU CURRENTLY SMOKE?_____IF NOT, WHEN DID YOU QUIT? _____

WHAT ALCOHOLIC BEVERAGES DO YOU DRINK?_____WEEKLY AMOUNT _____

CAFFEINATED BEVERAGES (SODA, COFFEE, TEA) AMOUNT PER DAY? _____

ARE YOU SEXUALLY ACTIVE? ☐ **YES** ☐ **NO** BIRTH CONTROL MEASURES? _____

LIST ALL MEDICATIONS YOU TAKE **(INCLUDING OVER THE COUNTER MEDICINES AND VITAMINS, HERBS, AND SUPPLEMENTS)**

NAME	DOSE	HOW OFTEN

ALLERGIES? **(Please check box and state reaction):**

☐ CT SCAN DYE_____ ☐ LATEX_____ ☐ IODINE_____

☐ FOODS/ENVIRONMENTAL_____

MEDICINES (Specify medicine & reaction) _____

_____

☐ NO KNOWN ALLERGIES **(Please check if you have no known allergies)**

NAME:_____

DATE OF BIRTH:_____

PLEASE MARK "YES" OR "NO" TO INDICATE WHETHER ANY OF THE FOLLOWING PROBLEMS HAVE BOTHERED YOU IN THE PAST SIX MONTHS:

REVIEW OF SYSTEMS	YES	NO	COMMENTS
BREAST			
Breast pain			
Breast lumps/mass			
Nipple discharge			
Breast skin changes			
Abnormal mammogram			
Abnormal breast MRI			
CONSTITUTIONAL			
Weight loss – Intentional?			Amount:
Fever or Chills			
Feeling tired, low energy			
Loss of appetite?			
ENT			
Ears			
Hearing difficulties			
Ringing in ears			
Nose/Mouth/Throat			
Trouble swallowing			
Hoarseness			
Mouth sores			
Bleeding gums			
Frequent nasal or sinus congestion or infections			
EYES			
Double vision			
Blurred vision			
Irritated or dry eyes			
Frequent tearing			
CARDIOVASCULAR			
Heart racing or pounding			
Irregular beats			
Chest tightness, pressure, or pain			
ENDOCRINE			
Night sweats			
Heat/cold intolerance			
Unusual hair loss			
GASTROINTESTINAL			
Frequent heartburn			
Nausea			
Vomiting			
Passed blood or black stools			
Constipation or diarrhea			

REVIEW OF SYSTEMS	YES	NO	COMMENTS
GENITOURINARY			
Genitourinary			
Pain or burning w/urination			
Trouble controlling urine flow			
Blood in urine			
Urination at night			# times:
Gynecologic			
Vaginal discharge			
Painful intercourse			
Still having periods?			
Menopause			
HEMATOLOGIC/LYMPH			
Excessive bleeding or bruising			
Frequent nosebleeds			
Enlarged glands or lymph nodes			Age:
IMMUNOLOGIC			
Previous blood transfusion?			When:
INTEGUMENTARY			
Skin rashes			
Dry, scaly skin			
Frequent itching			
Sores slow to heal			
MUSCULOSKELETAL			
Painful or stiff joints			
Difficulty with walking			
Back pain			
Muscle cramping			
Bone pain			
NEUROLOGIC			
Any numbness or tingling			Location:
Problem with balance or arm/leg weakness			
Frequent headaches			
PSYCHIATRIC			
Difficulty sleeping			
Feel anxious, worried			
Feel down, depressed			
Trouble with memory, confusion			
RESPIRATORY			
Frequent cough or wheezing			
Coughed up blood			
Increased shortness of breath			

NAME:_____

DATE OF BIRTH:_____

IF YOU ARE HAVING PAIN PROBLEMS, CIRCLE THE NUMBER BELOW THAT BEST DESCRIBES YOUR PAIN

0——1——2——3——4——5——6——7——8——9——10

NO PAIN — **DISTRESSING PAIN** — **UNBEARABLE PAIN**

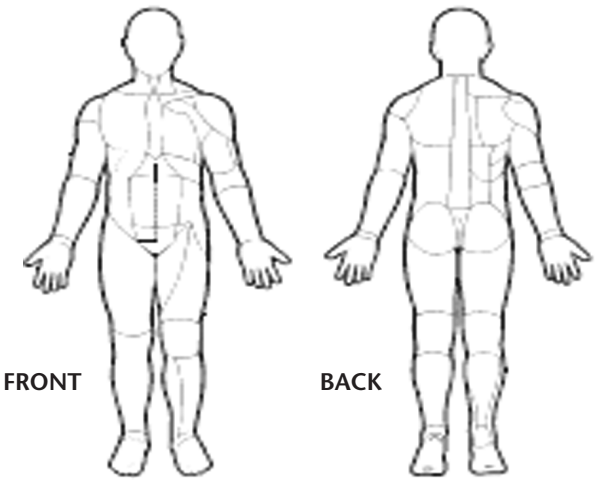
DOES ANYTHING MAKE IT BETTER OR WORSE? _____

_____

PLEASE CIRCLE ANY AREAS ON THE TWO FIGURES TO SHOW THE LOCATION OF YOUR PAIN.

Please circle the words that best describe your pain:

Throbbing	Dull
Achy	Cramping
Burning	Shooting
Sharp	Gnawing



DOES ANYONE LIVE WITH YOU? _____

ARE YOU CONCERNED ABOUT FAMILY MEMBERS OR OTHERS WHO RELY ON YOU FOR THEIR CARE?

☐ **YES** ☐ **NO** IF YES, WHO? _____

ARE YOU SAFE IN YOUR RELATIONSHIPS AND/OR SAFE IN YOUR HOME? ☐ **YES** ☐ **NO**

DO YOU NEED HELP WITH DAILY ACTIVITIES? ☐ **YES** ☐ **NO** *(CIRCLE ALL THAT APPLY)*

GROOMING STAIRS HOUSEWORK COOKING SHOPPING DRIVING

IS THERE SOMEONE TO HELP YOU WITH THESE TASKS? _____

DO YOU USE ANY EQUIPMENT AT HOME? ☐ **YES** ☐ **NO** *(CIRCLE ALL THAT APPLY)*

WALKER TUB BENCH CANE WHEELCHAIR RAISED TOILET SEAT HOSPITAL BED OXYGEN

IS THERE OTHER EQUIPMENT YOU NEED? _____

DO YOU HAVE CONCERNS ABOUT: *(CIRCLE ALL THAT APPLY)*

HEALTH INSURANCE FINANCES WORK RELATED ISSUES DISABILITY TRANSPORTATION

DO YOU HAVE OR WOULD YOU LIKE INFORMATION ABOUT A HEALTH CARE DIRECTIVE?

YES, I HAVE ONE_____ NO, I DO NOT HAVE ONE_____ NEED MORE INFORMATION_____

PLEASE SIGN_____ DATE _____

(PATIENT SIGNATURE)

REVIEWED BY:_____ DATE _____

(MD/NURSE SIGNATURES)

NAME:_____

DATE OF BIRTH:_____

MRN:_____

NUTRITION SCREENING TOOL

HAVE YOU LOST WEIGHT RECENTLY WITHOUT TRYING?	
NO	0
UNSURE	2
IF YES, HOW MUCH WEIGHT (LBS) HAVE YOU LOST?	
2-12 POUNDS	1
13-23 POUNDS	2
24-33 POUNDS	3
34-44 POUNDS	4
UNSURE	2
WEIGHT LOSS SCORE	
HAVE YOU BEEN EATING POORLY BECAUSE OF A DECREASED APPETITE?	
NO	0
YES	1
APPETITE SCORE	
(WEIGHT LOSS + APPETITE SCORES) TOTAL SCORE	
WOULD YOU LIKE A REFERRAL TO DIETITIAN? ☐ **YES** ☐ **NO**	

STAFF SECTION – STAFF TO COMPETE

AUTOMATIC REFERRAL TO DIETITIAN = SCORE >2 OR REQUESTED BY PATIENT

DOES PATIENT HAVE?	
HEAD AND NECK CANCER	**YES AUTOMATIC REFERRAL TO DIETITIAN**
GASTRIC CANCER	
LIVER CANCER	
LUNG CANCER	
ESOPHAGEAL CANCER	
PANCREATIC CANCER	
A FEEDING TUBE OR INTRAVENOUS (IV) NUTRITION	
DIETARY CONSULT ORDERED IN IKNOWMED	**YES**

FAMILY HISTORY FORM

NAME:_____

DATE OF BIRTH:_____

Please list all of your cancer diagnoses here:

Type of cancer	Age at diagnosis
1.	
2.	
3.	
4.	

Provider Use Only

- ☐ **Refer to genetic counselor** for hereditary risk assessment
  - ☐ iKM order placed for Genetic Counseling OR fax this form to 651-735-1827 (MN ONC) ☐ Other
- ☐ Fax to genetic counselor for **triage**; refer if meets criteria
- ☐ Reviewed; **does not meet NCCN criteria** for hereditary assessment

Family member	Still living?	Age at death	Cause of death	*Countries of origin of ancestors (prior to USA)	*Ashkenazi ethnicity? (Eastern European Jewish)
Father					
Paternal grandfather					
Paternal grandmother					
Mother					
Maternal grandfather					
Maternal grandmother					

How many of each do you have? How many still living?

	Total number:	Number living:		Total number:	Number living:
Brothers:			Paternal uncles:		
Sisters:			Paternal aunts:		
Sons:			Maternal uncles:		
Daughters:			Maternal aunts:		

Please list all relatives who have had any type of cancer here:

First name	Relationship to you	Side of the family? Father's / Mother's		Type of cancer	Age at diagnosis	Alive / deceased A	D

Please list relatives with other major health problems here:

First name	Relationship to you	Side of the family? Father's / Mother's		Health problem(s)	Age at diagnosis	Alive / deceased A	D

* Hereditary cancer rates may differ by country of origin/ethnicity and are higher in people with Ashkenazi ancestry.

PLEASE SIGN_____ DATE _____

(PATIENT SIGNATURE)

REVIEWED BY:_____ DATE _____

(CLINICIAN REVIEWER FOR REFERRAL DETERMINATION)