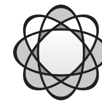


MINNESOTA ONCOLOGY

NEW PATIENT INFORMATION

FULL NAME________________________________**BIRTHDATE**______________

TELEPHONE: HOME (_____) ____________ CELL (_____) ___________ OTHER (_____) ____________

NAME YOU PREFER TO BE CALLED____________ NAME OF SPOUSE/SIGNIFICANT OTHER ____________

PRIMARY 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)____________
- ☐ COLITIS/DIVERTICULOSIS
- ☐ DIABETES
- ☐ FIBROMYALGIA
- ☐ TOXIC CHEMICAL EXPOSURE
  AGENT________________
- ☐ CHICKEN POX
- ☐ GOUT
- ☐ GLAUCOMA
- ☐ HEART ATTACK
- ☐ HIV / AIDS
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HEPATITIS
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ LUPUS / SCLERODERMA
- ☐ KIDNEY DISEASE/STONES
- ☐ PHLEBITIS/BLOOD CLOTS
- ☐ PNEUMONIA
- ☐ SEIZURES/EPILEPSY
- ☐ SHINGLES
- ☐ SKIN DISEASE/RASHES
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ THYROID PROBLEMS
- ☐ ULCERS/GASTRITIS

COMMENTS / OTHER: ____

____

____

____

____

MNO1042_1013

NAME:________________________________

DATE OF BIRTH:________________________

PREVIOUS CANCER TREATMENTS? ☐ **YES** ☐ **NO**

PLEASE DESCRIBE:____

IMMUNIZATIONS UP TO DATE? ☐ **YES** ☐ **NO** LAST FLU SHOT__________ PNEUMONIA SHOT ________

PROSTHETIC DEVICES OR IMPLANTS? ☐ **YES** ☐ **NO** TYPE:______________________________

LIST ALL OPERATIONS & HOSPITALIZATIONS AND APPROXIMATE YEAR: PLEASE INCLUDE ALL OPERATIONS, BIOPSIES, AND ENDOSCOPY PROCEDURES (FOR EXAMPLE, BREAST BIOPSY, COLONOSCOPY, ETC.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

FEMALES: AGE OF FIRST MENSTRUAL PERIOD ____________ AGE AT FIRST LIVE BIRTH__________________

LAST PAP SMEAR ________________________ LAST MENSTRUAL PERIOD ________________

LAST MAMMOGRAM ____________________ HORMONE REPLACEMENTS?______________

NUMBER OF PREGNANCIES________________ NUMBER OF LIVE BIRTHS _________________

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?______________ BIRTH CONTROL MEASURES? ___________________________

PLEASE 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
CONSTITUTIONAL			
Weight loss – Intentional? Y N			Amount:
Fever or Chills			
Feeling tired, low energy			
Loss of appetite?			
EYES			
Double vision			
Blurred vision			
Irritated or dry eyes			
Frequent tearing			
ENT			
Ears			
Hearing difficulties			
Ringing in ears			
Nose/Mouth/Throat			
Trouble swallowing			
Hoarseness			
Mouth sores			
Bleeding gums			
Frequent nasal or sinus congestion or infections			
CARDIOVASCULAR			
Heart racing or pounding			
Irregular beats			
Chest tightness,			
pressure, or pain			
RESPIRATORY			
Frequent cough or wheezing			
Coughed up blood			
Increased shortness of breath			
GASTROINTESTINAL			
Frequent heartburn			
Nausea			
Vomiting			
Passed blood or black stools			
Constipation or diarrhea			
GENITOURINARY			
Genitourinary			
Pain or burning w/urination			
Trouble controlling urine flow			
Blood in urine			
Urination at night			# times:

REVIEW OF SYSTEMS	YES	NO	COMMENTS
GENITOURINARY (CONT.)			
Gynecologic			
Vaginal discharge			
Painful intercourse			
Still having periods?			
Menopause			Age:
MUSCULOSKELETAL			
Painful or stiff joints			
Difficulty with walking			
Back pain			
Muscle cramping			
Bone pain			
INTEGUMENTARY			
Skin rashes			
Dry, scaly skin			
Frequent itching			
Sores slow to heal			
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			
ENDOCRINE			
Night sweats			
Heat/cold intolerance			
Unusual hair loss			
HEMATOLOGIC/LYMPH			
Excessive bleeding or bruising			
Frequent nosebleeds			
Enlarged glands or lymph nodes			
IMMUNOLOGIC			
Previous blood transfusion?			When:

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 (0) — **DISTRESSING PAIN** (5) — **UNBEARABLE PAIN** (10)

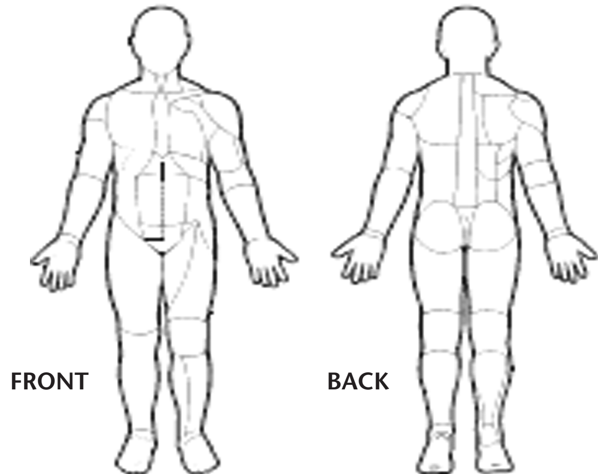
DOES ANYTHING MAKE IT BETTER OR WORSE? ____

____

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	
HAVE YOU BEEN EATING POORLY BECAUSE OF A DECREASED APPETITE?		
NO	0	
YES	1	
DO YOU HAVE?		
HEAD AND NECK CANCER GASTRIC CANCER LIVER CANCER LUNG CANCER ESOPHAGEAL CANCER PANCREATIC CANCER A FEEDING TUBE OR INTERVENEOUS (IV) NUTRITION		
WOULD YOU LIKE A REFERRAL TO A DIETITIAN?	YES	
TOTAL		

SCORE OF 2 OR MORE REFER TO THE DIETITIAN

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) ☐ 612-863-0235 (Allina) ☐ 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 may 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)