Patient Packet

Forms contained:
1. Patient History
2. Medication List
3. Patient Checklist

Please complete these forms before arriving for your appointment.
Name of Patient: ___________________ DOB___________ Age _________
Date form completed_________ Race/Ethnicity___________ Gender (circle) M  F
Marital Status_________ Education________________ Primary Language __________
Address:
_____________________- Interpreter Needed  Y or N
_____________________- Home Phone: ( ) ________________
_____________________- Work Phone: ( ) ________________
_____________________- Cell/Other: ( ) ________________
_____________________- Email address ________________
Preferred method of contact (please circle):   Home__Work__Cell__Email
Reason for visit/referral: (please indicate site, if appropriate)__________________________

Referring Physician(s) (please note if you want this individual to be informed of health related decisions and treatment plans.):
Name ________________________________ Send Correspondence? Y or N
Specialty________________________ Phone Number ( ) ________________
Address _______________________________
City ___________________ State _______ Zip Code __________________
Primary Care Physician Name ______________________________
Send Correspondence? Y or N     Phone Number ( ) ________________
Address ______________________________
City ___________________ State _______ Zip Code __________________
**Pregnancy History:**
Age of first pregnancy: _____ # of pregnancies: ______

**Lactation History:**
Have you ever breast fed: Y or N
If yes, for how long? (total for all children, if possible): ______

**Menstrual History:**
Age of First Menstrual Period: ______ Age at menopause: ______
If pre-menopausal: Date of Last Menstrual Period: ______
Are your menstrual periods regular: Y or N
If yes, # of days in cycle: ______

If you require a treatment that may impair your fertility, would you like information regarding the options for preserving your reproductive ability, if possible? (please circle) Y or N

**Hormone Use:**
Have you ever used hormone replacement therapy? (please circle) Y or N
If yes, for how long? ______ Name of medication: ______
Are you currently taking hormone replacement? (please circle) Y or N
If yes, for how long? ______ Name of medication: ______
Have you ever taken oral contraceptives? (please circle) Y or N
Are you presently bothered by symptoms related to menopause such as hot flashes? (please circle) Y or N Uncertain N/A

**If you are a male have you had a PSA Test?** (please circle) Y or N Uncertain
If your answer is yes, what was the date of your last PSA Test? ______
Result: Normal (circle) Abnormal (explain): ______

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The Emory Clinic Inc.
Winship Cancer Institute
Patient History
Prior Hospitalizations/Medical Problems:

Have you ever been diagnosed with a tumor (benign or cancerous) previously? Y or N

Please list all previous tumors:

<table>
<thead>
<tr>
<th>Site of tumor</th>
<th>Date of Diagnosis</th>
<th>Date of Last Treatment</th>
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Medical History: please include prescription & over the counter medications

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<th>Medication (include dose)</th>
<th>Medication (include dose)</th>
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Blood Transfusion History:

Have you ever received a blood or blood product transfusion? Y N

If Yes: Date__________ Location Received (hospital name)________

Allergies: Please list all medication and dye-related allergies.

<table>
<thead>
<tr>
<th>Medication/Food/Substance</th>
<th>Allergic Reaction</th>
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</table>
Date of Last Colonoscopy: ____________________________
Result: Normal (circle) Abnormal (explain): ________________

Date of Last Pap Smear: ____________________________
Result: Normal (circle) Abnormal (explain): ________________

Date of Last Mammogram: ____________________________
Result: Normal (circle) Abnormal (explain): ________________

Breast Self Examination: Do you perform breast self-examinations? Y or N
If yes, how frequently? Monthly (circle) other (please specify) ________________

Have you ever had or do you currently have any of the following: (please check all that apply)
- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Goiter
- Adrenal Problems
- Cushing's Disease
- Hepatitis A, B, C
- Jaundice
- Liver Disease
- Peptic Ulcer Disease
- Gastric Reflux
- Crohn’s Disease
- Ulcerative Colitis
- HIV/AIDS
- Kidney Disease
- Bleeding Disorders
- Leukemia/Lymphoma
- Thrombocytopenia/ITP
- Tuberculosis
- Asthma
- Pneumonia
- High blood pressure
- Peripheral Vascular Disease
- Stroke or TIA
- Heart Attack/Angina
- Cardiac Disease
- Congestive Heart Failure
- Pulmonary Edema
- High Cholesterol
- Acute Pancreatitis
- Chronic Pancreatitis
- Kidney Stones
- Gall Stones
- Gastrointestinal Bleeding
- Emphysema
- Other___________
- Other___________
- Other___________

Please list all previous hospitalizations (including surgery): ____________________________

________________________________________

Social History:

Do you or have you ever:
Used tobacco: Y or N (please check) Cigarettes____ Cigars____ Chewing Tobacco____ Pipe____
If yes, how much and for how long? ________________
Drank alcohol?  Y  or  N
Number of beers/week: __________ # of years ______
Number of shots/drinks of hard alcohol/week: ______ # of years ______
Number of glasses of wine/week: ______ # of years ______
Do you or have you ever used recreational drugs (cocaine, heroine, marijuana) or been addicted to prescription drugs?  Y  or  N
If yes, please describe ____________________________________________________________

What is your current occupation? __________________________________________________
If not your present occupation, what is the occupation you held for the longest period of time? ___________________________ For how long? ___________________________

To the best of your knowledge, were you ever exposed to any occupational hazards (such as asbestos, radiation, coal dust, etc.)? ___________________________

Family History:
List all medical condition of your family members including cancer:

<table>
<thead>
<tr>
<th>Paternal Grandfather</th>
<th>Maternal Grandfather</th>
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<tbody>
<tr>
<td>Paternal Grandmother</td>
<td>Maternal Grandmother</td>
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<td>Father</td>
<td>Mother</td>
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<td>Sibling</td>
<td>Sibling</td>
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<td>Sibling</td>
<td>Sibling</td>
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<tr>
<td>Child</td>
<td>Child</td>
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<tr>
<td>Others (list):</td>
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</table>

Review of Systems:
Do you presently have any of the following (please check all that apply):

Constitutional:
☐ No concerns
☐ Weakness
☐ Fatigue
☐ Lack of Appetite
☐ Fevers
☐ Night Sweats
☐ Weight Loss
☐ Malaise
☐ Chills
☐ Difficulty Sleeping

Psychological:
☐ No concerns
☐ Depression
☐ Anxiety
☐ Agitation
☐ Suicidal Thoughts
☐ Memory
difficulty/forgetfulness

Neurologic:
☐ No concerns
☐ Extremity/muscular weakness
☐ Gait instability
☐ Dizziness
☐ Blurry vision
☐ Paralysis
☐ “Pins and Needles” (parasthesias)
☐ Loss of vision
☐ Headaches
☐ Double vision
☐ Loss of sensation
☐ Difficulty in speaking
☐ Blackouts
☐ Confusion/Difficulty in thinking
### Endocrine:
- **No concerns**
- Goiter
- Heat Intolerance
- Cold Intolerance
- Weight loss
- Weight gain
- Tremors
- Change in voice

- Increase in facial/body hair
- Decrease in facial/body hair
- Change in menstrual periods/Loss of menstrual periods

- (not related to menopause)
- Excessive thirst
- Increased urination
- Increased appetite

### Skin:
- **No concerns**
- Dryness of skin
- Excessive itching
- Rash (persistent)

- Change in skin color
- Changes in finger/toe nails

- Skin ulcers/bruising
- New moles/spots

### Lymphatics:
- **No concerns**
- “Swollen nodes or glands”

- Bumps under arms, in groin or in neck

- Swelling of arms or legs

### Cardiovascular:
- **No concerns**
- Arrhythmia or “funny heart beat”
- Chest pain
- Heart Attack
- Palpitations
- Tightness of Chest

- Shortness of breath
- Exercise intolerance
- Need to sleep on more than 1 pillow
- Calf pain with walking distances

- Swelling of the legs
- Heart Murmur
- Shortness of breath lying down/unable to lie flat

### Respiratory:
- **No concerns**
- Dry Cough
- Productive Cough
- Coughing up Blood

- Wheezing
- Asthma
- Shortness of breath

- Pain with breathing
- Stridor
- Hay fever

### Ears, Eyes and Throat:
- **No concerns**
- Blurred vision
- Spots in your eyes
- Pain in the eyes
- Eye infections
- Difficulty hearing
- Ringing in the ears
- Pain in the ears

- Discharge from the ears
- Nosebleeds
- Rhinorrhea (runny nose)
- Chronic stuffy nose
- Sinus trouble
- Hay fever
- Houseness

- Neck Pain
- Throat Pain
- Dental problems
- Oral sores
- Bleeding gums
- Decreased vision
### Gastrointestinal:
- **No concerns**
- Anorexia (loss of appetite)
- Early satiety
- Nausea
- Vomiting
- Jaundice
- Abdominal Pain
- Heartburn
- Reflux
- Diarrhea

### Urinary Tract:
- **No concerns**
- Pain with urination
- Burning with urination
- Incomplete voiding
- Frequency

### Genital Tract
- **No concerns**

#### Male:
- Difficulty attaining an erection
- Persistent erections

#### Female:
- Vaginal discharge
- Pain with intercourse

### Musculoskeletal:
- **No concerns**
- Painful joints
- Swollen joints

### Medical Devices/Implants/Other:
- **No concerns**
- Indwelling catheter
- Hepatic Infusion Pump
- Dialysis access
- Insulin pump
- Automated Intracardiac Defibrillator (AICD)
- Pacemaker
- VP Shunt
- Peritoneal Dialysis Catheter
- Orthopedic implants
For Breast Patients: (If you have had a mastectomy, complete the following only for the existing breast, if you have had a bilateral mastectomy, please go on to the next section.)

Have you ever had a prior breast biopsy?  Y  or  N  If yes, circle type and write the number of times on the line:

- Fine Needle
- Breast Lumpectomy
- Core Needle Biopsy
- Surgical Biopsy

Subsequent/Other Breast Surgery:

Have you had any other surgery on your breasts?  (please circle)  Y  or  N  (If yes, please complete the section below.)

Which of the following other procedures have you had?

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>Right</th>
<th>Left</th>
<th>Date</th>
<th>Hospital Performed</th>
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<tbody>
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<td>Implants</td>
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<td>Breast Reduction</td>
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<td>Other (please specify):</td>
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Thank you.
Medication List

Patient Name: _________________    Date: ________________

Please provide a list of all the medications you take. This list must include vitamins, over-the-counter remedies, items from health food stores, and all herbal remedies. In order to help provide you with safe care, we check to make sure that there are no known interactions with cancer fighting drugs and your medications. If you are unable to make a list of the medications, bring them with you and we will write them down. You will take the medications back home with you after your appointment.

<table>
<thead>
<tr>
<th>Medication or Supplement</th>
<th>Dosage or amount taken</th>
<th>How taken</th>
<th>How often taken</th>
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<tbody>
<tr>
<td>Example: Aspirin</td>
<td>Example: 81 mg</td>
<td>Example: by mouth</td>
<td>Example: once a day</td>
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I am allergic to the following medications:

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<thead>
<tr>
<th>Medication (Example: codeine)</th>
<th>Reaction (Example: vomiting)</th>
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New Patient Checklist

Thank you for choosing Winship Cancer Institute for your healthcare. The Winship referral office obtained your medical records prior to scheduling you for your first appointment. If you think there are more recent records since that time, please bring copies with you.

The following is a list of items you need to bring with you for your first appointment.

- Insurance card
- Driver’s license or alternate photo ID
- Medication list: Please include all prescription and over-the-counter medications you are currently taking.
- X-ray films, CT, PET, and/or MRI scans (only if available)
- Pathology slides (only if available): Pathology slides are used to diagnose the type of disease you may have.

In addition to the above required items, we also suggest you bring the following with you to your appointment.

- Friend or family member: Your first appointment may be a little overwhelming. A friend or family member can help in asking your doctor all the right questions and in remembering all that is discussed during your appointment.
- Questions for your Doctor: Consider bringing your questions in a written form. This will help remember what questions you want answered. Bring a pen and notebook so you have a place to write the answer to your questions.
- Snack: You may be here a lengthy amount of time for your first appointment. A snack can help if you are hungry and can not get something to eat right away.
- Light jacket or sweater: The waiting areas and exam rooms can be cool at times.
- Reading materials

As a new patient to Winship, you will be scheduled to meet with the Financial Department approximately an hour before your first appointment with your physician. Please note that if you are scheduled to see more than one medical provider, you will be asked to provide multiple co-pays for these visits. These payments can be made by cash, check, or credit card.