Medical Oncology Care ASSOCIATES

INITIAL CONSULT WORKSHEET

Patient Name _____ DOB _____ Date: _____

Did a physician refer you ❑ YES ❑ NO

Referring Physician's Name _____ Phone _____

Address _____ City/Zip. _____

MEDICINES

(currently used regularly or occasionally) List non-prescription medicines on last line. (None ❑)

Name of Medicine	Dose (mg)	Frequency of use (times per day)

ALLERGIES

Have you had any reactions to:

Latex, rubber, or adhesive tape ❑ Yes ❑ No Seafood, iodine, or contrast dye for x-rays ❑ Yes ❑ No

Bee stings ❑ Yes ❑ No Hives, skin rash, trouble breathing, or other severe reactions to medicines ❑ Yes ❑ No

If "Yes" to the last question, list below:

Medicine/other substance	Type of reaction

SOCIAL HISTORY

Highest education level (grade) attained ❑ G.E.D ❑ H.S.Diploma ❑ College Degree _____ ❑ Other _____

Are you presently employed ❑ Yes ❑ No Occupation

Prior Occupations _____

Have you had any occupational exposure to asbestos, metals, chemicals, etc. ❑ Yes ❑ No

If Yes, Describe _____

Do you smoke tobacco ❑ Yes ❑ No Type & frequency _____ How long _____

In the past ❑ Yes ❑ No Type & frequency _____ How long _____

When stopped _____ Did your mother smoke ❑ Yes ❑ No Did your father smoke ❑ Yes ❑ No

Do you drink alcohol ❑ Yes ❑ No Type & frequency _____ How long _____

In the past ❑ Yes ❑ No Type & frequency _____ How long _____

When stopped _____

HOME ENVIRONMENT/COMMUNICATION ASSESSMENT

(Physician: Elaborate when appropriate)

Are you currently married ❑ Yes ❑ No if yes, how long _____ ❑ Divorced ❑ Widowed ❑ Single

Do you have problems with your

Ability to see ❑ Yes ❑ No Describe _____ Do you wear glasses/contacts ❑ Yes ❑ No

Ability to speak ❑ Yes ❑ No Describe _____ Do you have speaking aids ❑ Yes ❑ No

Ability to hear ❑ Yes ❑ No Describe _____ Do you have hearing aids ❑ Yes ❑ No

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REVIEW OF SYSTEMS

			Physician Comments
Headaches, confusion, memory lapses, seizures, slurred speech, Arm or leg weakness	❑ Yes	❑ No	
Vision loss or blurring, double vision; eye pain	❑ Yes	❑ No	
Non-healing or slow healing sore in mouth (gums, tongue, throat, etc.)	❑ Yes	❑ No	
Hoarseness; weakness or loss of voice	❑ Yes	❑ No	
New cough or change in usual cough	❑ Yes	❑ No	
Coughed up blood (plain or mixed with spit)	❑ Yes	❑ No	
Chest pain or pressure; irregular or rapid heart beat; heart valve	❑ Yes	❑ No	
Swelling in legs or feet; pain in the calves when walking	❑ Yes	❑ No	
Loss of appetite: change in taste; fill up early when eating	❑ Yes	❑ No	
Difficulty or pain while chewing, drinking, or swallowing	❑ Yes	❑ No	
Indigestion, heartburn, nausea, vomiting, or stomach trouble	❑ Yes	❑ No	
Significant diarrhea or constipation; recent change in bowel habits	❑ Yes	❑ No	
Blood in stool or tarry looking stool	❑ Yes	❑ No	
Skin rash or sore: change in a mole	❑ Yes	❑ No	
Pain, stiffness, swelling or heat in joints; pain in any bone or back	❑ Yes	❑ No	
Pain anywhere else in the body	❑ Yes	❑ No	
Anxiety, depression, trouble falling asleep or staying asleep	❑ Yes	❑ No	
Any lumps or bumps (skin, lymph nodes or glands, breasts, testicles, etc.)	❑ Yes	❑ No	
Easy or excessive fatigue	❑ Yes	❑ No	
Fever or night sweats	❑ Yes	❑ No	
Itching	❑ Yes	❑ No	
Abdominal swelling or bloating	❑ Yes	❑ No	
New moles or change in a mole	❑ Yes	❑ No	
Diabetes; thyroid or adrenal problems	❑ Yes	❑ No	
Excessive bleeding or bruising	❑ Yes	❑ No	

Usual weight _____ lbs. Wt. lost in last 6 months _____ lbs. Wt. lost in last 3 months _____

FEMALES ONLY

Mammogram within 1 year ❑ Yes ❑ No Date of last mammogram _____

Pelvic exam within 1 year ❑ Yes ❑ No Date of last pelvic exam _____

Pap smear within 1 year ❑ Yes ❑ No Date of last pap smear _____

Still menstruating ❑ Yes ❑ No Age when started menstruation _____

If Yes, regular periods ❑ Yes ❑ No Blood loss/pattern typical ❑ Yes ❑ No

If No, natural menopause ❑ Yes ❑ No Surgical menopause ❑ Yes ❑ No Age _____

Other _____

Might you be pregnant ❑ Yes ❑ No

Have you ever been pregnant ❑ Yes ❑ No If yes, how many times _____

Age at first pregnancy _____ Age at last pregnancy _____ Age of first menstrual period _____

Are you taking any hormones ❑ Yes ❑ No If yes, what hormones are you taking _____

Abortions ❑ Yes ❑ No Miscarriages ❑ Yes ❑ No If Yes, explain below

MALES ONLY

Prostate exam within 1 year ❑ Yes ❑ No Date of last prostate exam _____

PSA within 1 year ❑ Yes ❑ No If Yes, was it ❑ Normal ❑ Abnormal

Any trouble with starting urine, dribbling, getting up more than 2x/night to urinate ❑ Yes ❑ No

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PAST MEDICAL HISTORY

(Physician: Elaborate in comments or in notes when appropriate)

Have you ever had any of the following illnesses or conditions in the past?

			Comments				Comments
Stroke/TIA	❑ Yes	❑ No		Liver disease/hepatitis	❑ Yes	❑ No	
Glaucoma/Cataracts	❑ Yes	❑ No		Kidney/Bladder disease	❑ Yes	❑ No	
Thyroid disease	❑ Yes	❑ No		Diabetes	❑ Yes	❑ No	
High blood pressure	❑ Yes	❑ No		High blood fats, cholesterol	❑ Yes	❑ No	
Heart disease	❑ Yes	❑ No		Abnormal bleeding	❑ Yes	❑ No	
Vein trouble/blood clots	❑ Yes	❑ No		Anemia	❑ Yes	❑ No	
Female problems	❑ Yes	❑ No		Joint disease	❑ Yes	❑ No	
Prostate problems	❑ Yes	❑ No		Tuberculosis, pneumonia	❑ Yes	❑ No	
Lung disease	❑ Yes	❑ No		Anxiety/depression	❑ Yes	❑ No	
Stomach/bowel disease	❑ Yes	❑ No		Psychiatric illness	❑ Yes	❑ No	
Cancer	❑ Yes	❑ No		Lymphoma/Leukemia	❑ Yes	❑ No	
Autoimmune disease	❑ Yes	❑ No		Other	❑ Yes	❑ No	

Have you ever had any serious injuries or broken bones? ❑ Yes ❑ No Explain _____

Have you ever received a blood transfusion? ❑ Yes ❑ No Explain _____

Immunizations

Flu (within 1 year)	❑ Yes	Year _____	❑ No	❑ Unknown
Hepatitis B	❑ Yes	Year _____	❑ No	❑ Unknown
Pneumonia	❑ Yes	Year _____	❑ No	❑ Unknown
Tetanus (w/in 10 yrs)	❑ Yes	Year _____	❑ No	❑ Unknown

SURGERY

(Please list all prior surgeries and hospitalization dates)

_____

_____

_____

FAMILY HISTORY

(Physician: Elaborate in comments or in notes when appropriate

Father alive ❑ Yes ❑ No Age _____ If No, age of death _____ Cause of death _____

Mother alive ❑ Yes ❑ No Age _____ If No, age of death _____ Cause of death _____

Any brothers ❑ Yes ❑ No How many alive _____ Age(s) _____

How many deceased? _____ Age(s) _____ Cause of death _____

Any sisters ❑ Yes ❑ No How many alive _____ Age(s) _____

How many deceased? _____ Age(s) _____ Cause of death _____

Any children ❑ Yes ❑ No How many alive _____ Age(s) _____

How many deceased? _____ Age(s) _____ Cause of death _____

Father's race:

❑ White (not Hispanic origin) ❑ Black (not Hispanic origin) ❑ Hispanic ❑ Asian/Pacific Islander ❑ Native American/Native Alaskan

Mother's race:

❑ White (not Hispanic origin) ❑ Black (not Hispanic origin) ❑ Hispanic ❑ Asian/Pacific Islander ❑ Native American/Native Alaskan

Indicate illnesses which have occurred in Parents, Grandparents, Aunts, Uncles, Brothers, Sisters

			Identify Family Members	Physician's Comments
Cancer	❑ Yes	❑ No		
Heart disease	❑ Yes	❑ No		
High blood pressure	❑ Yes	❑ No		
Strokes	❑ Yes	❑ No		
Bowel disease	❑ Yes	❑ No		
Diabetes	❑ Yes	❑ No		

Patient's signature _____ Date _____

Signature of person assisting patient with this form _____ Date _____

Relationship to patient _____