Patient Packet

Forms contained:

1. Patient History
2. Medication List
3. Patient Checklist

Please complete these forms before arriving for your appointment.

EMORY HEALTHCARE

The Emory Clinic Inc.

Winship Cancer Institute

Patient History

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 _____

EMORY HEALTHCARE

The Emory Clinic Inc.

Winship Cancer Institute

Patient History

Pregnancy History: **N/A**

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: **N/A**

Have you **ever** used hormone replacement therapy? (please circle) Y N

If yes, for how long? _____ Name of medication _____

Are you **currently** taking hormone replacement? (please circle) Y N

If yes, for how long? _____ Name of medication _____

Have you ever taken oral contraceptives? (please circle) Y N

Are you presently bothered by symptoms related to menopause such as hot flashes? (please circle) Y N Uncertain **N/A**

If you are a male have you had a PSA Test? (please circle) Y N Uncertain

If your answer is yes, what was the date of your last PSA Test? _____

*Result: Normal (circle) Abnormal (explain):*_____

Prior Hospitalizations/Medical Problems:

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

Please list all previous tumors:

Site of tumor	Date of Diagnosis	Date of Last Treatment

Medical History: please include prescription &over the counter medications

Medication (include dose)	Medication (include dose)

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.*

Medication/Food/Substance	Allergic Reaction

EMORY HEALTHCARE

The Emory Clinic Inc.

Winship Cancer Institute

Patient History

Date of Last Colonoscopy: _____

Result: Normal (circle) Abnormal (explain): _____

Date of Last Pap Smear: _____ **N/A**

Result: Normal (circle) Abnormal (explain): _____

Date of Last Mammogram: _____ **N/A**

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 Mellitus(sugar)
- ☐ 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/IT P/TTP
- ☐ 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_____
- ☐ 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:

Paternal Grandfather_____ Maternal Grandfather_____

Paternal Grandmother_____ Maternal Grandmother_____

Father_____ Mother_____

Sibling_____ Sibling_____

Sibling_____ Sibling_____

Child_____ Child_____

Others (list): _____

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
- ☐ Hoarseness
- ☐ 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
- ☐ Constipation
- ☐ Bloody vomiting
- ☐ Blood in stool
- ☐ Pain with bowel movements
- ☐ Pain with swallowing/difficulty swallowing
- ☐ Unable to swallow foods
- ☐ Black/Tarry stools
- ☐ Stools that float/oily in appearance/foul smelling
- ☐ Food intolerance (i.e. fatty foods)
- ☐ Abdominal cramping/bloating

Urinary Tract:

- ☐ **No concerns**
- ☐ Pain with urination
- ☐ Burning with urination
- ☐ Incomplete voiding
- ☐ Frequency
- ☐ Urgency (think you have to go but you don't)
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ large volume of urine
- ☐ Difficulty starting to urinate
- ☐ Incontinence
- ☐ Repeated Urinary Tract Infections

Genital Tract

- ☐ **No concerns**

Male:

- ☐ Difficulty attaining an erection
- ☐ Persistent erections
- ☐ Discharge from penis
- ☐ Pain with intercourse
- ☐ Testicular Pain
- ☐ Mass in testicles/penis

Female:

- ☐ Vaginal discharge
- ☐ Pain with intercourse
- ☐ Vaginal/Labial Mass/ Ulcer
- ☐ Change in menstrual flow
- ☐ "extra" periods/excessive bleeding

Musculoskeletal:

- ☐ **No concerns**
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Changes in limbs (lumps, swelling)
- ☐ Muscle pain
- ☐ Back pain
- ☐ Pain down either/both legs

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

EMORY HEALTHCARE

The Emory Clinic Inc.

Winship Cancer Institute

Patient History

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?

Procedure Type	Right	Left	Date	Hospital Performed
Implants				
Breast Reduction				
Breast Reconstruction				
Other (please specify):				

Thank you.

EMORY | WINSHIP CANCER INSTITUTE

A Cancer Center Designated by the National Cancer Institute

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.

Medication or Supplement	Dosage or amount taken	How taken	How often taken
Example: Aspirin	Example: 81 mg	Example: by mouth	Example: once a day

I am allergic to the following medications:

Medication (Example: codeine)	Reaction (Example: vomiting)

EMORY | WINSHIP CANCER INSTITUTE

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.