Patient Intake Form

Name: _____ Date of birth _____

Medication Allergies YES NO

If yes please list the medications and reactions: _____

_____

Food Allergies YES NO Please list: _____

Latex Allery: YES NO

_____

_____

List all medications (include vitamins and supplements) if more please bring in a list

DRUG	DOSE	FREQUENCY

Have you ever had a colonoscopy YES NO If yes When and with who _____

Do you take Aspirin? YES NO

If yes:

Dose: _____

Frequency: _____

Do you take Ibuprofen/Motrin? YES NO

If yes:

Dose: _____

Frequency: _____

Last Flu Vaccination _____ Month/yr.

Pneumonia Vaccination _____ Month/yr.

Last Mammogram _____ Month/yr.

Last Pap exam _____ Month/yr.

Height: _____ Weight: _____

Do you smoke? YES NO

How many times day? _____

How many years? _____

Have you ever smoked? YES NO

When did you quit? (What year) _____

Do you use any other substances? YES NO

If yes what? _____

How often do you use? _____

Do you use Alcohol? YES NO

How many times day? _____

How many years? _____

Patient Registration and Consent for Treatment Form

NAME: _____

Do you have an implantable cardiac device?

Pace Maker **OR** Implantable defibrillator
If yes – Please bring your information card for your chart.

The following questions are required to ask as part of the meaningful use insurance requirements:

Race: _____ Primary Language _____

Ethnicity (select one)

☐ Spanish/ Hispanic Origin ☐ Not of Spanish / Hispanic Origin

☐ Pt declined/unknown ☐ OTHER

Emergency Contact: _____ Relationship _____

Phone number: _____

Pharmacy Name: _____ Pharmacy Location: _____

Primary Care Physician: _____

Referring Provider: _____

Specialty Providers
(Urologist/Gastroenterologist/Cardiologist) _____

_____

It is very important to use to understand how you learned about our practice (please circle all that apply)

Primary Care Physician	Emergency Rm	Website	Phone book
Urology	Urgent Care	Newspaper	TV advertisement
GYN/OB	VA Hospital	Cancer Services	
GI/Gastroenterology	Friend or Family Member	Facebook	Twitter

OTHER: _____

Do you have a medical power of attorney, living will, or advance directive? ☐ YES ☐NO ☐ I don't know

If you have one of the above, please bring a copy for your file here. If you have questions about a medical power of attorney, living will, or advance directive, please ask your provider during your appointment.

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
(Y) N	*EXAMPLE: Colon Cancer*	45	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
Y N	BREAST CANCER							
Y N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS							
Y N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

Y N Are you concerned about your personal and/or family history of cancer?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Patient's Signature:_____ Date: _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

For Office Use Only: Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED NA

Follow-up appointment scheduled: YES NO Date of Next Appointment:_____

Patients affected family members recommend to have genetic testing YES NO

If family member declines patient is instructed to contact RCRS for further testing

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Colon Cancer - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60[ll]
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ 10 or more cumulative colorectal adenomas at any age

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome, MAP, AFAP, or FAP syndrome mutation in the family
- ☐ One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age

[ll] MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

**Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas

^Cancer history should be on the same side of the family

[T] Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

[+] In the same individual or on the same side of the family