



**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 Allergy:              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.

Do you smoke?      YES    NO

How many times day? \_\_\_\_\_

How many years? \_\_\_\_\_

Last Mammogram \_\_\_\_\_ Month/yr.

Last Pap exam \_\_\_\_\_ Month/yr.

Have you ever smoked?      YES    NO

When did you quit? (What year) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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: \_\_\_\_\_ DOB: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**Do you have an implantable cardiac device? YES NO**

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  
Urology  
GYN/OB  
GI/Gastroenterology

Emergency Rm  
Urgent Care  
VA Hospital  
Friend or Family Member

Website  
Newspaper  
Cancer Services  
Facebook 

Phone book  
TV Advertisement  
Radio Advertisement  
Twitter 

OTHER: \_\_\_\_\_

**Do you currently volunteer or attend any school? YES NO if so where \_\_\_\_\_**

**Current Employer: \_\_\_\_\_**

**Employers Address: \_\_\_\_\_**

**Employers Phone No.: \_\_\_\_\_**

**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
<input checked="" type="radio"/> Y <input type="radio"/> N EXAMPLE: <i>Colon Cancer</i>	45	-----	--	Aunt Cousin	45 61	Grandmother	53
<input type="radio"/> Y <input type="radio"/> N BREAST CANCER							
<input type="radio"/> Y <input type="radio"/> N OVARIAN CANCER <i>(Peritoneal/Fallopian Tube)</i>							
<input type="radio"/> Y <input type="radio"/> N UTERINE/ENDOMETRIAL CANCER							
<input type="radio"/> Y <input type="radio"/> N COLON/RECTAL CANCER							
<input type="radio"/> Y <input type="radio"/> N 10 or more LIFETIME COLON POLYPS							
<input type="radio"/> Y <input type="radio"/> N OTHER CANCER(S) <i>(Specify cancer type)</i>	Among others, consider the following cancers: <i>Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate</i>						

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<sup>||</sup>
- 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<sup>^</sup>
- 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<sup>^</sup>
- Three or more relatives with a Lynch syndrome cancer at any age<sup>^</sup>
- 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

<sup>||</sup> MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

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

<sup>^</sup>Cancer history should be on the same side of the family

<sup>T</sup>Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

<sup>+</sup>In the same individual or on the same side of the family