RCRS
ROCHESTER COLON & RECTAL SURGEONS, P.C.
ROCHESTERCOLON.COM

Patient Intake Form

Name: _____ Date of birth _____

DO YOU HAVE A PACEMAKER OR ICD? **YES** **NO**
(Implantable Cardiac Device)

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:_____ 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.

Have you been vaccinated against COVID-19? YES NO

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 & Phone number: _____

Relationship _____

Pharmacy Name: _____

Pharmacy Location: _____

Primary Care Physician: _____

Referring Provider: _____

Specialty Providers (Urologist/Gastroenterologist/Cardiologist) _____

_____

It is very important to us 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: _____

Y / N								
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