Oncology **Date:_____**

Patient Registration

Diagnosis:_____

Name: _____ **I prefer to be called**: _____
Last First MI

Date of Birth: _____ **Birthplace**: _____ **Social Security Number:** _____

Address: _____**City**:_____**State**:_____**Zip:** _____ **County:** _____

Home # (_____) _____ **Cell #** (_____) _____ **Work #** (_____)_____

Email Address_____

Which numbers may we use? ☐ Home ☐ Cell ☐ Work May we leave a message? ☐ Yes ☐ No

Check Appropriate Box:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Retired ☐ Disabled Occupation: _____ Employer: _____

Have you served in the military ☐ No ☐ Yes Where _____ When _____

Retirement Date: _____

Spouse's Name: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Race: □ Caucasian □ American Indian □ Asian **Ethnicity:** □ Hispanic □ Non-Hispanic
□ African American □ Native Hawaiian □ Alaskan
□ Unknown □ Other _____ □ Decline to Answer

Advance directives: Do you have an Advanced Directive □ Yes □ No

Preferred Main Language: □ English □ Spanish □ Arabic □ Other_____

What is the highest level of education you completed?

- ❑ -8th grade or less
- ❑ -Some high school, but did not graduate
- ❑ -High school graduate or GED
- ❑ -Some college or 2-year degree
- ❑ -4-year college graduate
- ❑ -More than 4-year college degree

Whom may we thank for referring you? _____

Physician Information

Family/Primary Physician _____ **Phone:** _____

Address _____ **Fax :**_____

Referring Physician: _____ **Phone**: _____

Address _____ **Fax** :_____

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Insurance Information

Primary Insurance

Name of Insured _____DOB_____SSN# _____

Relationship to Patient: Self Spouse Dependent Other

Insurance Company_____ Grp #_____ ID#_____

Secondary Insurance

Name of Insured _____DOB_____SSN# _____

Relationship to Patient: Self Spouse Dependent Other

Insurance Company_____ Grp #_____ ID#_____

New Patient History

Current Problem

Current Please describe briefly how your current problem started. What were your symptoms?

_____

_____

_____

_____

Cancer History

Type of your cancer: _____ Date of Diagnosis: _____

If you have had previous treatment, please include type of treatment below:

Treatment with surgery: ☐ Yes ☐ No When & Where: _____

Radiation Therapy: ☐ Yes ☐ No When & Where: _____

Chemotherapy: ☐ Yes ☐ No When & Where: _____

Medical History

Please check if you have had any of the following medical conditions

☐ Anemia	☐ Gallbladder Disease	☐ Pacemaker / Defibrillator
☐ Arthritis	☐ Acid Reflux	☐ Anxiety
☐ Asthma	☐ Glaucoma	☐ Seizures
☐ Bleeding Disorders	☐ Heart Disease	☐ Stomach Ulcers
☐ Breast Disease	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease
☐ COPD/Emphysema	☐ High Cholesterol	☐ Tuberculosis
☐ Depression	☐ HIV/AIDS	☐ Heart Attack
☐ Diabetes	☐ Kidney Disease	☐ Lupus/Scleroderma

Additional Comments:_____

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Surgical History

Please list all surgeries, major diseases, illnesses, or conditions for which you have been hospitalized:

Surgeries or hospitalizations	Date	Where
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4. _____	_____	_____

Social History

Religious Belief	☐Catholic ☐Jewish ☐Protestant ☐Muslim ☐Other: _____
Have you been exposed to:	☐Asbestos ☐Chronic Fumes ☐Chronic Dust ☐Radiation ☐Toxic Chemicals ☐Others: _____
Alcohol Use	How many alcoholic beverages do you drink per week:_____
Smoking Status	❑ Never smoked ❑ Current Smoker: How many years have you smoked? _____ How many cigarettes do you smoke a day? _____ ❑ Quit When did you quit? _____ How many years did you smoke? _____ How many cigarettes did you smoke per day? _____ □ Cigarettes □ Marijuana □ Cigars or pipes □ Chewing tobacco ☐Hookah □ Other_____

FAMILY HISTORY

Include blood relatives only. Do not include anyone adopted, foster, step-relatives, or those related by marriage. List any current ages or age at time of death.

Relative	Age	Alive Y/N?	Had Cancer Y/N?	If yes, What type?	Died of Cancer Y/N?	Other Medical Problems Y/N?	If yes, list medical problem (heart disease, diabetes, etc.)
Mother							
Father							
Mother's Mother							
Mother's Father							
Father's Mother							
Father's Father							
Daughter 1							
Daughter 2							
Daughter 3							
Daughter 4							
Son 1							
Son 2							
Son 3							
Son 4							
Sister							
Sister							
Sister							
Brother							
Brother							
Brother							
Other							
Other							

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Female History

Menstrual History

Age when menstruation began? _____

Are you still having monthly periods? □ Yes □ No

Is your menstruation slight, moderate, heavy, or irregular? _____

Are you presently using an IUD or birth control pills? _____

Date of your last menstrual cycle: _____

Is there any possibility you could be pregnant at this time? □ Yes □ No

Menopause

If you are no longer having a menstrual cycle, at what age did your monthly periods stop? _____

Did your menopause occur as a result of: □ Natural □ Surgery □ Following chemotherapy?

Do you experience hot flashes? □ Yes □ No

Any previous history of hormone use

Contraceptive Hormone use: □ No □ If yes, for how many years: _____

Post Menopause Hormones: □ No □ If yes, for how many years: _____

Pregnancies

Number of pregnancies: _____

Number of children born alive: _____

What was your age at your first pregnancy? _____

Current Medication List

List all medications you are taking, including vitamins, nonprescription drugs, and herbal supplements.

Bring all Medications to your first appointment

Drug	Dose	Frequency	Ordering Physician	Date Started

Retail Pharmacy Name: _____ Phone# (_____) _____-_____

Pharmacy Address: _____ Fax #: (_____) _____-_____

Mail Order Pharmacy Name: _____ Phone# (_____) _____-_____

Do you have prescription coverage? □ Yes □ No

Allergy Information

Latex Allergy □ Yes □ No Iodine Allergy □ Yes □ No

OTHER ALLERGY INFORMATION	REACTION	Date/Year Started

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Name:_____ Date:_____

Authorized Patient Communication List

Patient or authorized person: I authorize any physician, hospital, or medical care facility to provide all information regarding my medical history and treatment to the Karmanos Cancer Institute. Photocopies of this form may be considered to be as valid as the original.

(Optional) Patient or authorized person: I authorize Karmanos Cancer Institute to discuss my medical condition and/or release medical information the following people (i.e. family members):

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Patient Signature: _____ Date:_____