Bayhealth
Kent General - Milford Memorial

ONCOLOGY NEW PATIENT – INTAKE FORM

Patient Label

DEMOGRAPHIC INFORMATION:

Name:		Date of Birth (mm/dd/yyyy):	
Address:		Home Phone:	
City:		Work Phone:	
State & Zip Code:		Cell Phone:	
Who do you live with?		Marital Status:	
Employer:		Emergency Contact:	
Primary Insurance:		Phone: Address:	
Secondary Insurance:			
Family Physician:			
Referring Physician:			
		Community Pharmacy: Telephone: Address:	

To be completed by Patient:

Patient Race and Ethnicity
Please mark "X" in the boxes that apply to your race and origin:

1.Race

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian Pacific Island
- ☐ Other (write in race)_____
- ☐ Unknown

2.Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Other

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SOCIAL HISTORY:

Do you (or have you ever) smoked cigarettes?	☐ Yes ☐ No If 'Yes' how much _____ and how long _____
Do you (or have you ever) drink alcohol?	☐ Yes ☐ No If 'Yes' how much _____ and how long _____
Do you (or have you ever) used illegal drugs?	☐ Yes ☐ No If 'Yes' how much _____ and how long _____
What is your occupation? (if retired, list former occupation)	

Have you ever worked in any of the following occupations or industries: (check all that apply)

☐ Battery manufacturing	☐ Nuclear, aircraft or medical devices industries
☐ Carpentry, furniture or cabinet-making	☐ Pesticide application
☐ Computer manufacturing	☐ Production of plastics, rubbers, or dyes
☐ Firefighting	☐ Painting
☐ Hairdressing	☐ Sandblasting or brickmaking
☐ Healthcare	☐ Shift work (e.g., long-term night shift work, or rotating shift work) in any occupation
☐ General construction and shipbuilding	

How many years have you lived in Delaware? (please circle box below)

Less than 1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30 + years	Never a Delaware resident

FAMILY HISTORY:

Any history of cancer with family members?	☐ Yes ☐ No If 'Yes', who and what kind?
Any history of "blood" disorders (i.e. anemia, leukemia, bleeding or clotting problems) in your family members? If so, who and what kind?	☐ Yes ☐ No If 'Yes', who and what kind?

MEDICAL HISTORY:

Prior Chemotherapy?	☐ Yes ☐ No When:	Medication Allergies:	
Prior Radiation Therapy?	☐ Yes ☐ No When:	Other Allergies:	
Past Medical Conditions:		Previous Surgeries:	

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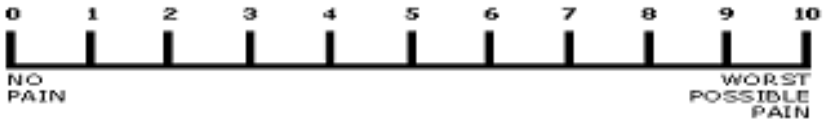
GENERAL CONDITION:

Performance Status Scale: My current health allows me to : (Check the most appropriate response)

☐	0	Be fully active and carry on all normal activity
☐	1	Perform activities such as light house work, office work, shopping, etc but not able to perform strenuous activities
☐	2	Take care of myself, but not perform light work. I am out of bed/chair more than half of the day & I get out of the house
☐	3	Stay pretty much at home, in bed/chair more than half of the day, but I am able to take care of myself to some degree
☐	4	Be confined to bed or chair all of the time

PAIN ASSESSMENT: Circle the number that describes your worst pain in the past 24 hours:

No Pain: score = 0
Mild Pain: score = 1 – 3
Moderate Pain: score = 4 – 7
Severe Pain: score = 8 - 10



SYMPTOMS: Please check symptoms you currently have or have had recently.

Constitutional
- ☐ Chills
- ☐ Feeling poorly
- ☐ Feeling well
- ☐ Fever
- ☐ Poor appetite
- ☐ Recent weight change
- ☐ Sweats
- ☐ Swollen glands

Genitourinary
- ☐ Blood in urine
- ☐ Burn/painful urination
- ☐ Frequent urination
- ☐ Get up to urinate at night x_____
- ☐ Lack of bladder control
- ☐ Slow urinary flow

Cardiovascular
- ☐ Chest discomfort
- ☐ Chest pain
- ☐ Dizziness
- ☐ Excessive sweating
- ☐ Fainting
- ☐ Feet/leg swelling
- ☐ Heart beats too fast
- ☐ Irregular heart rate
- ☐ Poor circulation

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ No eye pain
- ☐ Poor vision
- ☐ Tearing

Gynecology
- ☐ Bleeding
- ☐ Irregular bleeding
- ☐ Pain
- ☐ Vaginal discharge

Ears/Nose/Mouth/Throat
- ☐ Choking
- ☐ Difficulty swallowing
- ☐ Dry
- ☐ Ear discomfort
- ☐ Hearing loss or ringing
- ☐ Hoarseness/voice change
- ☐ Nasal discharge
- ☐ Sinus complaints
- ☐ Tongue pain

Neurological
- ☐ Headaches
- ☐ Lightheaded/dizziness
- ☐ Nosebleeds
- ☐ Numbness/tingling
- ☐ Paralysis/stroke
- ☐ Tremors

Gastrointestinal
- ☐ Belly pain
- ☐ Bleeding
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea/vomiting
- ☐ Painful bowel movements

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Hot flashes

Psychiatric
- ☐ Anxiety
- ☐ Excessive fatigue
- ☐ Insomnia

Skin
- ☐ Bruise easily
- ☐ Change in color
- ☐ New masses
- ☐ Nodules
- ☐ Rash or itching
- ☐ Sore won't heal
- ☐ Ulcerative lesions

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Sputum

Musculoskeletal
- ☐ Back pain
- ☐ Bone pain
- ☐ Joint pain
- ☐ Muscle pain/cramps
- ☐ Numbness
- ☐ Weakness

Hematology
- ☐ Bruising
- ☐ Delayed healing
- ☐ Mucosal bleeding
- ☐ Nosebleeds

Breast
- ☐ Breast pain
- ☐ New palpable masses
- ☐ Nipple discharge
- ☐ Numbness

Signature of individual completing form: _____ Date/Time: _____