William E. Kahlert
REGIONAL CANCER CENTER

Patient Label

General Registration Information Today's Date:

PATIENT NAME		**DATE OF BIRTH**	
PRIMARY PHONE		**CELL PHONE**	
EMAIL ADDRESS			

SEX (CIRCLE)	**FEMALE**	**MALE**			
MARITAL STATUS (CIRICLE)	**MARRIED**	**DIVORCED**	**SEPERATED**	**WIDOWED**	**SINGLE**
PREFERRED COMMUNICATION METHOD (CIRCLE)		**PHONE**	**TEXT**	**EMAIL**	

Reason for Today's Visit	
Referring Physician	

EMERGENCY CONTACT NAME	
RELATION	
PRIMARY CONTACT NUMBER	
ALTERNATE CONTACT NUMBER	
EMAIL ADDRESS	

PLEASE LIST INDIVIDUALS THAT YOUR HEALTH CARE TEAM HAS PERMISSION TO SHARE YOUR HEALTH INFORMATION WITH. THE FIRST NAME LISTED WILL BE CONSIDERED THE PRIMARY POINT OF CONTACT.

NAME	
RELATION	
CONTACT NUMBER	
NAME	
RELATION	
CONTACT NUMBER	
NAME	
RELATION	
CONTACT NUMBER	
NAME	
RELATION	
CONTACT NUMBER	

Patient Signature	
Date	

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General Registration Information

Providers/ Other Physicians			
Name	Specialty	Phone Number	Wish to have records sent (yes or no)

Previous Surgeries, Procedures or Hospitalizations **(please include surgery, biopsies etc.)**			
Name of Procedure	Date	Reason	Where Performed

Previous Radiation Therapy?	No	Yes	If yes, where?
Pacemaker/ Defibrillator?	No	Yes	Do you have a copy of the Device Card?

SOCIAL HISTORY

Occupation:			
If Retired- Previous Work:			
Children?	YES	NO	# of children
Do you live alone?	YES	NO	If no, with whom do you live?
Do you drive?	YES	NO	If no, who takes you to your appointments?
History of substance abuse?	YES	NO	If yes, what type?
Do you smoke?	YES	NO	If yes or in the past: ***How many packs per day***
	How many years?		***When did you quit?***
Do you drink alcohol?	YES	NO	If yes, how often?

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Any Changes in your Current Activity	YES	NO
If yes, explain:		
How much of the day are you sitting or in bed?		

FAMILY HISTORY

MEMBER		ALIVE	Deceased	AGE	HEALTH STATUS OR CAUSE OF DEATH	History of Cancer and Type
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Mother						
Father						
Sisters	#					
Brother	#					
Son	#					
Daughter	#					
Other Family members with history of cancer? (who and type)						

Allergies (List all medication, food and other allergies)	
Allergic to	**Reaction**

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Current Medication List **(List ALL prescriptions, over-the-counter medicines and dietary supplements)**

Medication	Dose	When and how taken	Date started (approx.)	Prescribing Doctor

PREFERRED PHARMACY AND PHONE NUMBER	
MAIL ORDER PHARMACY (IF APPLICABLE)	

Prescription **Medication Plan Information** **(fill all applicable areas)**	
Name of plan	
Policy Holder Name	
Policy Holder DOB	
Member ID	
Group Number	
Claims Address	
Phone Number	
Fax Number	

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MEDICAL HISTORY
(Please circle all that apply and add date of diagnosis or onset)

Rheumatologic			
Arthritis	Gout	Osteoporosis	Lupus
Neurologic			
Alzheimer's Disease	Migraines	Multiple Sclerosis	Parkinson's Disease
Stroke	Seizures		
Mental Health			
Anxiety	Depression	Bi-polar Disorder	Schizophrenia
Endocrine			
Goiter	Graves' Disease	Hashimoto's	Hypo/Hyperthyroidism
Diabetes Type I	Diabetes Type II		
Lungs			
Asthma	COPD	Emphysema	
Hematologic			
Blood Clotting Disorder	Sickle Cell Anemia	Anemia	
Skin			
Eczema	Psoriasis	Rosacea	Shingles
Heart			
Arrhythmias	Heart Attack/MI	Heart Murmur	High Blood Pressure
High Cholesterol	Congestive Heart Failure		
Gastrointestinal			
Crohn's	Colitis	Acid Reflux/GERD	Irritable Bowel (IBS)
Stomach Ulcers	Diverticulitis		
Liver			
Hepatitis A	Hepatitis B	Hepatitis C	Cirrhosis
Kidney and Bladder			
Kidney stones	Kidney infection	Urinary tract infection	
Other			
Hearing Problems	Mononucleosis	Tuberculosis	HIV/ AIDS
Scleroderma	Collagen Vascular Disease	Sjogren's	
Other pertinent history not listed above:			

Female Specific Questions:		
Age of first menstruation: _____	Age/Date of last menstruation _____	Birth control (YES / NO) How many years: _____
Number of Pregnancies _____	Date of last mammogram: _____	Date of last Colonoscopy: _____

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Hysterectomy Date:_____	Hormone replacement therapy after menopause (Yes / No) How long:_____	Sexually active: **YES** **NO**

Male Specific Questions:		
Last PSA: _____	Date of last colonoscopy: _____	Sexually active: **YES** **NO**

Symptom Review (Check all symptoms experienced currently or within the last month)

☐ Abdominal Pain	☐ Black or tarry stools	☐ Constipation	☐ Diarrhea
☐ Nausea	☐ Vomiting	☐ Indigestion	☐ Loss of appetite
☐ New Cough	☐ Shortness of breath	☐ Blood in urine	☐ Joint pain
☐ Joint swelling	☐ Loss of strength	☐ Muscle pain	☐ Swelling
☐ Implanted Metal Location:	☐ Prosthesis Location:	☐ Chills	☐ Difficulty Sleeping
☐ Fatigue	☐ Fever	☐ Night Sweats	☐ Weight Loss last 90 days #LBS:
☐ Weight Gain last 90 days #LBS:	☐ Easy bruising	☐ Swollen Lymph Nodes	☐ Lump or mass
☐ Double Vision	☐ Vision Loss	☐ Ringing in the ears	☐ Hearing Problems
☐ Bleeding gums	☐ Nose bleeds	☐ Difficulty Swallowing	☐ Oral Ulcer
☐ Dental problems	☐ Neck swelling	☐ Vertigo	☐ Rash
☐ Persistent infections	☐ Other not listed:		