William E. Kahlert
REGIONAL CANCER CENTER
CARE BRAVELY

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 (CIRCLE)	MARRIED	DIVORCED	SEPARATED	WIDOWED	SINGLE
Preferred Learning Style	Written Instruction	Verbal Instruction	Use of Audio/Visual	Computer/Web based	Other:

Reason for Today's Visit	
Referring Physician	

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.

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

Patient Signature	
Date	

Patient Label

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?**
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 what type**
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Mother						
Father						
Sisters	#					
Brothers	#					
Sons	#					
Daughters	#					

Other family members with history of cancer? (who and type)

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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

Pharmacy Information (Please provide information on where you get your prescriptions filled)

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

Prescription Medication Plan Information (If different fill all applicable areas)

Name of plan	
Policy Holder Name	
Policy Holder DOB	
Member ID	
Group Number	
Claims Address	
Phone Number	
Fax Number	

Allergies (List all medication, food and other allergies)

Allergic to	Reaction

Providers/ Other Physicians

Name	Specialty	Phone Number	Reason for seeing this physician	Wish to have records sent (yes or no)

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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:

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Previous Surgeries, Procedures or Hospitalizations (please include surgery, biopsies etc.)

Name of Procedure	Date	Reason	Where Performed

Female Specific Questions:			
Age of first menstruation:	Age/Date of last menstruation:	Birth control: YES NO If yes, how many years:	Number of Pregnancies: Number of Live Births: Age at 1st birth:
Date of last mammogram:	Hysterectomy: YES NO If yes, date of hysterectomy:	Hormone replacement therapy after menopause? YES NO If yes, how long:	Sexually active: YES NO
Date of last Colonoscopy:			

Male Specific Questions:		
Last PSA:	Date of last Colonoscopy:	Sexually active: YES NO

Other Pertinent Medical Information			
Previous Radiation Therapy?	No	Yes	**If yes, where?** **When?**
Pacemaker/ Defibrillator?	No	Yes	**Do you have a copy of the Device Card?**
Autoimmune Disease	**No**	**Yes**	**Specify which disease:**

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Review of Systems

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

	Constitutional		Eyes		Ears
☐	Fever/Chills	☐	Vision changes	☐	Hearing loss
☐	Drenching night sweats	☐	Eye pain	☐	Vertigo
☐	Weight changes	☐	Dryness	☐	Ear pain
☐	Appetite change	☐	Redness	☐	Drainage from ears
☐		☐		☐	Ringing in ears
	Nose/Mouth/Throat		**Cardiovascular**		**Respiratory**
☐	Nasal congestion	☐	Chest pain	☐	Cough
☐	Runny nose	☐	Palpitations	☐	Shortness of breath
☐	Sore throat	☐		☐	Wheezing
☐	Mouth sores	☐		☐	Coughing up blood
☐	Dry mouth	☐		☐	Painful breathing
☐	Hoarseness	☐		☐	
	Gastrointestinal		**Genitourinary**		**Musculoskeletal**
☐	Diarrhea	☐	Frequent urination	☐	Joint pain
☐	Constipation	☐	Blood in urine	☐	Joint swelling
☐	Blood in stool/Black stool	☐	Trouble urinating	☐	Back pain
☐	Abdominal pain	☐	Incontinence	☐	Bone pain
☐	vomiting	☐	Change in abdominal girth	☐	
☐	Heartburn	☐	Vaginal bleeding	☐	
☐	Difficulty swallowing food	☐	Lumps in testicles	☐	
☐	Painful swallowing	☐	Painful intercourse	☐	
☐		☐	Vaginal discharge	☐	
	Skin		**Neurological**		**Psychiatric**
☐	Rash	☐	Headaches	☐	Anxiety
☐	Lesion	☐	Dizziness	☐	Depression
☐	Redness	☐	Confusion	☐	
☐	Warmth	☐	Numbness/Tingling	☐	
☐	Swelling	☐	Slurred speech	☐	
☐		☐	Unsteady walking	☐	
☐		☐	Memory loss	☐	
	Hematologic/Lymphatic		**Allergic/Immunologic**		**Endocrine**
☐	Bruising	☐	Itching	☐	Problems with sugar
☐	Bleeding	☐	Sneezing	☐	Lumps in breasts
☐	Swollen glands	☐	Watery eyes	☐	Nipple drainage or bleeding
☐	Transfusion	☐	Recurrent infections	☐	