CCNW New Patient Questionnaire

Today's Date:

What is the reason for your visit today?	
Name:	Date of Birth:
Personal Environment	
Support Systems: ☐ Lives w/spouse, signif other, family or friends ☐ Lives alone ☐ Lives in own house	
☐ Lives in nursing home ☐ Lives in assisted living facility ☐ Incarcerated ☐ Homeless	
☐ Transportation problems exist and will require assistance	
☐ Other support system issues:	
Home Health Care agency/Nursing Home? (If applicable)	
Phone:	
Pharmacy Name:	
Location:	Phone:
Previous Oncology Treatments	
☐ Have you ever received Chemotherapy before?	
Dates:	
Facility:	
☐ Have you ever received Radiation Therapy before?	
Dates:	
Facility:	
☐ Have you ever had genetic testing?	
If yes, date & test company *(if known):*	
Comments:	

* For Women Only *	
Number of pregnancies:	Age at first period:
Number of children:	Last menstrual period:
Age at first birth:	Menstrual cycle length:
# of interrupted pregnancies:	Menopause status: ☐ Pre ☐ Peri ☐ Post ☐ Unknown
Hormone Use History: ☐ Any Hormone Use ☐ Contraceptive Hormone Use ______ # Years Used ☐ Post-menopause Use ______ # Years Used ☐ Other Hormone Use ______ # Years Used	Age at menopause: Reason for Menopause: ☐ Natural ☐ Chemotherapy ☐Ovaries Removed ☐ Other:
Did you ever breast feed?	How many sisters do you have?
Date of last PAP smear:	How many daughters do you have?
Do you do breast self-exams?	How many sisters did your mother have?
Date of last mammogram:	How many sisters did your father have?
Do you know your breast density? ☐ extremely dense ☐ heterogeneously dense ☐ scattered fibroglandular ☐ mostly fatty	

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* For Men Only *	
Date of last testicular exam:	Do you perform testicular self-exams:
Date of last prostate exam:	
Have you ever had a PSA drawn:	If yes was it normal:
Comments:	

If you have been seen by a Providence provider within the last 3 months, *skip the following sections:* ***Drug Allergy**, **Medication List**, **Medical Conditions/Diagnoses, Surgical History & Additional History***

Drug Allergy	Type of Reaction (Example: Hives)

Allergic to: ☐ Latex ☐ Tape ☐ Iodine ☐ Barium ☐ IV Contrast (dye)

Medication/Vitamins/Herbs	Dose	Approx Start Date	Directions/Frequency (i.e. daily, twice daily, etc.)
Please list all prescriptions and over-the-counter medications that you take, including vitamins and herbs.			

Medical Conditions/Diagnoses

Diagnosis	Age of Diagnosis	Comments

Surgical History

Procedure	Date	Right/Left	Comments

Other Surgeries/Procedures:

Additional History

Smoking Status

☐ Yes- current every day smoker
☐ Yes- current some day smoker
☐ Yes- but quit
☐ Never

Smoking History

# of Years: _________

# of Packs/Day: _________

# of Years Quit: _________

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Products

☐ Cigarettes ☐ Cigars ☐ Recreational drug use:

☐ Chewing tobacco ☐ e-Cigarettes ☐ Illicit drug use:

☐ Pipe ☐ Snuff

Alcohol Consumption

☐ Yes- current every day drinker

☐ Yes- current occasional drinker

☐ Yes- but quit # of Years Quit: _________

☐ Never

Alcohol History

Drinks/Week: Glasses of wine: _________

Cans of beer: _________

Shots of liquor: _________

Mixed drink with .05oz alcohol: ________

Comments:

Hazardous Materials

☐ Asbestos

☐ Lead

☐ Radon

☐ Other hazardous exposure:

☐ Benzene

☐ Radiation

☐ Other petroleum products:

Colon Health

Have you had a colonoscopy? ☐Yes ☐No

Where?

Date:

Were any colon polyps removed? ☐Yes ☐No

If yes, how many?

Family Cancer History

If any of your family members have or had cancer, please provide relevant information below.

Genetics Counseling patients only: info collected via CancerIQ online survey, please skip this section.

Type of Cancer	Relationship	Mother's Side / Father's side (M/F)	Age of Diagnosis	Alive or Deceased	Age of Death

Are you of Ashkenazi Jewish decent? *(used for genetic cancer risk assessment)* ☐Yes ☐No

Additional Comments:

_______________________________ Person completing this form (please print)

_______________________________ Relationship to patient

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