NEW PATIENT INTAKE FORM

PATIENT NAME: ________________________________ **DATE:** ___________

DATE OF BIRTH: _____________________ **AGE:** ________

PRESENTATION (WHY YOU ARE REQUESTING AN EVALUATION):

____
____
____

RISK FACTORS:

I have a **personal history of cancer** as follows: ☐ **N/A**

☐ Pancreatic ☐ Melanoma ☐ Prostate ☐ Colon ☐ Kidney ☐ Bladder ☐ Brain ☐ Thyroid ☐ Stomach

☐ Lymphoma ☐ Leukemia ☐ Other cancer(s): ____

Details of personal history of cancer (age of diagnosis): _____________________________________

____

____

FAMILY HISTORY:

I have a **family history of cancer** as follows: ☐ **N/A** ☐ Breast ☐ Ovarian ☐ Uterine ☐ Cervical

☐ Pancreatic ☐ Melanoma ☐ Prostate ☐ Colon ☐ Kidney ☐ Bladder ☐ Brain ☐ Thyroid ☐ Stomach

☐ Lymphoma ☐ Leukemia ☐ Other cancer(s): ____

Details of family history of cancer (first name and relationship of affected person with you, age at diagnosis):

____

____

I have a known familial genetic mutation in the family as follows: ☐ BRCA1 ☐ BRCA2 ☐ CHEK2 ☐ ATM ☐ PALB2 ☐ MLH1 ☐ MSH2 ☐ MSH6 ☐ PMS2 ☐ OTHER MUTATION: ____________________________

I have a known genetic mutation as follows: ☐ BRCA1 ☐ BRCA2 ☐ CHEK2 ☐ ATM ☐ PALB2 ☐ MLH1 ☐ MSH2 ☐ MSH6 ☐ PMS2 ☐ OTHER MUTATION: ____

***Please have any prior testing reports faxed to 208-277-3448 prior to your appointment**

PAST MEDICAL HISTORY:

Approximate Height: ___________ Approximate Weight: ______________

☐ **Heart problems:** ☐ **Prior heart attack (MI)** ☐ **Congestive heart failure** ☐ **Atrial fibrillation**

☐ **Other heart rhythm issue** ☐ **I take a blood thinner**

☐ **Lung problems:** ☐ **COPD** ☐ **Asthma** ☐ **History of blood clots (DVT/PE)**

☐ **Diabetes** ☐ **Hypertension** ☐ **Arthritis** ☐ **Stroke (CVA)**

☐ **Other medical problems: ____**

MEDICATIONS (PLEASE LIST NEATLY):

____

____

____

____

ALLERGIES (PLEASE LIST NEATLY): ☐ No Allergies

____

TOBACCO: ☐ Never smoker ☐ Former smoker ☐ Current smoker: ____________________________

ALCOHOL: ____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Divorced ☐ Work: __________________________ ☐ Retired

☐ **Significant current stressors: ____**

☐ **Other factors: ____**

REVIEW OF SYSTEMS (LIST NEATLY ANY SYMPTOMS):

GENERAL: ____

SKIN: ____

HEART: ____

LUNGS: ____

ABDOMINAL: ____

NEURO: ____

CLOTTING/BLOOD DISORDERS: ____