Hudson Valley Cancer Center

HOPE BEGINS HERE

Welcome to Hudson Valley Cancer Center. We are an Oncology Hematology group that specializes in all cancers and blood disorders. We are attaching our registration forms, new patient form and questionnaire so that you may take your time and fill out at home.

It is important for us to care for the unique needs of every patient so we ask that you fill out the forms in it their entirely. It will help us take the best care of YOU! Please come 15 minutes prior to your appointment time so the forms can be reviewed with our staff. You may bring a referral note from the physician whom referred you to us. You must bring all your labs, pathology reports, all radiology reports and surgical reports the day of your appointment along with the forms in this package.

If you have any questions, please contact us at 845-454-1942.

HUDSON VALLEY CANCER CENTER

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date of Consult:** _____

PHYSICIAN LIST: Please list contact information for other providers so we can co-ordinate your care on your behalf.

NAME	SPECIALTY	TELEPHONE	FAX
Referred by:			
Primary Care Provider:			

MEDICATIONS: Please list all prescription and over the counter medications, including supplements.

NAME	No. of PILLS	DOSE	FREQUENCY	REASON

ALLERGIES: ☐ None. If you have allergies, please list them below:

Name of Drug/Item	Reaction

Reviewed and reconciled with patient _____. Initials.

PAST MEDICAL HISTORY:

☐ High cholesterol ☐ High BP ☐ Diabetes ☐ COPD/Emphysema ☐ Stroke ☐Heart disease

☐ Heart attack ☐ Kidney disease ☐ Liver disease ☐ Bleeding/bruising ☐ Thyroid disease

☐ Peptic ulcer ☐ Depression ☐ Anxiety ☐ Osteopenia ☐ Osteoporosis

☐ Spine disc disease

☐ Cancer: Specify Type, Treatment & approximate dates: _____

_____

Other conditions not listed above: _____

_____

_____

_____

PAST SURGICAL HISTORY:

Type of Surgery/Procedure & Reason	Approximate Year

PAST GYNECOLOGIC HISTORY:

Number of Pregnancies _____ Number of live births _____

Number of abortions _____ Number of miscarriages _____ Which trimesters? _____

Age at 1st child birth _____ Age at last child birth _____ Age of 1st menses _____ Last menstrual period _____

Menstrual history: How many days? _____ How often? _____ How many tampons/pads a day? _____

Did you ever use oral contraceptives? _____. If yes, then for how long? _____ When did you stop? _____

Did you ever use estrogen replacement therapy? _____. If yes, for how long? _____ When did you stop? _____

Reviewed and reconciled with patient _____. Initials.

FAMILY HISTORY: Specifically related to Cancer, blood problems:

Relative	How many?	Diagnosis, approximate AGE of Diagnosis & whether alive or deceased & current Age
Mother	N/A	
Father	N/A	
Brothers		
Sisters		
Sons		
Daughters		

Others relatives:

Mother's side: _____

_____

Father's side: _____

_____

SOCIAL HISTORY:

Smoking: Number of packs a day _____ for _____ years. When did you quit? _____

Alcohol: Number of drinks a week _____ for _____ years. When did you quit? _____

Drug use: ☐ No ☐ Yes. List names of drugs used: _____

Last used: _____ If yes, any intravenous drug use? _____

HEALTH MAINTENANCE:

Last Flu shot: Month/Year it was administered? _____ Where was it administered? _____

Last Colonoscopy: Year: _____ and Name of Doctor: _____

Last Mammogram: Year: _____ Last Pap Smear: Year: _____

Last Prostate cancer screening and PSA: _____

Reviewed and reconciled with patient _____. Initials.

REVIEW OF SYSTEMS

Please check off active complaints:

CONSTITUTIONAL: ☐ Fevers ☐ Chills ☐ Night sweats
☐ Weight loss ☐ Fatigue ☐ Loss of appetite

ENT: ☐ Hearing loss ☐ Ringing in ears

HEMATOLOGIC: ☐ Spontaneous bruising ☐ Excessive Gum bleeding ☐ Prolonged bleeding
☐ Blood clots

ENDOCRINE: ☐ Excessive thirst ☐ Intolerance to cold ☐ Intolerance to heat
☐ Hoarse voice

CARDIAC: ☐ Chest pain ☐ Palpation ☐ Short of breath on lying down
☐ Short of breath at rest

PULMONARY: ☐ Dry Cough ☐ Coughing up blood ☐ Coughing up colored phlegm
☐ Pain on deep breathing ☐ Short of breath on walking

GASTROINTESTINAL: ☐ Difficulty swallowing ☐ Painful swallowing ☐ Abdominal pain
☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea
☐ Vomiting blood ☐ Black stool ☐ Blood in stool ☐ Bowel incontinence

GENITOURINARY: ☐ Frequent urination ☐ Burning on urination ☐ Hard to start urinating
☐ Incontinence ☐ Blood in urine

MUSCULOSKELETAL: ☐ Swollen joints ☐ Painful joints ☐ Edema ☐ Back pain

NEUROLOGIC: ☐ Headaches ☐ Loss of balance ☐ Tingling ☐ Numbness
☐ Weakness ☐ Seizures

REPRODUCTIVE: ☐ Heavy periods ☐ White/Yellow discharge ☐ Vaginal bleeding after menopause

Reviewed and reconciled with patient _____. Initials.