# ANNE ARUNDEL MEDICAL CENTER
# NEW PATIENT INFORMATION FORM
# AMBULATORY SERVICES

Date: _____ Reason For Your Visit: _____
Name: _____ Date of Birth: _____
E-mail: _____ Cell Phone: _____

Referring Physician: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Other Physicians: _____ Phone: _____
_____ Phone: _____

**ALLERGIES**: _____ None
Medicine Allergy: _____ Reaction: _____
Medicine Allergy: _____ Reaction: _____
Food Allergy: _____ Reaction: _____
Other Allergy: _____ Reaction: _____

Pharmacy Name: _____ Phone: _____
Address: _____ Fax: _____

**What is your preferred learning method?** O Listening O Reading O Demonstration O Picture/Videos O Other

**ANESTHESIA:** Have you ever had anesthesia? O Yes O No
If yes, did you have any severe or major complications with anesthesia? O Yes O No
If yes, please explain: _____
Have your Parents or Siblings had any severe or major complications with anesthesia? O Yes O No

| MEDICAL HISTORY | DESCRIPTION |
|---|---|
| O HIV/Aids | _____ |
| O Hepatitis | _____ |
| O Lung Disease | _____ |
| O Asthma | _____ |
| O Heart Disease | _____ |
| O Heart Attack | _____ |
| O Stroke | _____ |
| O DVT/PE | _____ |
| O Kidney Disease | _____ |
| O Urinary Problems | _____ |
| O Stomach Problems | _____ |
| O Diabetes | _____ |
| O High Blood Pressure | _____ |
| O High Cholesterol | _____ |
| O Psychiatric Disease | _____ |
| O Prostate Problems | _____ |
| O Tuberculosis (TB) | _____ |
| O Bowel Problems | _____ |
| O GYN Problems | _____ |
| O Sexually Transmitted Disease | _____ |
| O Abnormal Pap Smear | _____ |
| O Thyroid Disease | _____ |
| O Cancer | _____ |

| PAST SURGICAL HISTORY | DATE OF SURGERY | SURGEON/HOSPITAL |
|---|---|---|
| O Tonsillectomy | _____ | _____ |
| O Gallbladder | _____ | _____ |
| O Hysterectomy | _____ | _____ |
| were your ovaries removed? O Yes O No | | |
| O Breast Surgery | _____ | _____ |
| O Head/Neck Surgery | _____ | _____ |
| O Stomach/Intestinal | _____ | _____ |
| O Colon/Rectal Surgery | _____ | _____ |
| O Lung Surgery | _____ | _____ |
| O Heart Surgery | _____ | _____ |
| O Pelvic Surgery | _____ | _____ |
| O Prostate Surgery | _____ | _____ |
| O Back Surgery | _____ | _____ |
| O Other Surgery | _____ | _____ |
| O Other Surgery | _____ | _____ |
| O Other Surgery | _____ | _____ |

O Other Medical/Surgical: _____
_____
_____
_____
_____
_____
_____

**PREVIOUS CANCER TREATMENT** O Yes O No

| | Body Part | Facility | Physician Name | Year |
|---|---|---|---|---|
| Radiation Therapy | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | **Name of Drugs** | **Facility** | **Physician Name** | **Year** |
| Chemotherapy | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |

**SOCIAL HISTORY**

Are you: O SINGLE O MARRIED O WIDOWED O DIVORCED O SEPARATED
What is your current occupation: _____ Previous occupations: _____
Are you working now: O Yes O No
If yes, are you working: O Full-Time O Part-time If no, did you stop working because of your illness? O Yes O No
Have you been exposed to : Radon O Yes O No Asbestos O Yes O No Tuberculosis O Yes O No

Do you currently smoke: O Yes O No Did you ever smoke: O Yes O No How many years: _____
How many packs/day: _____ Quit date: _____ Would you like information about quitting: O Yes O No
Would you like to speak with a smoking cessation counselor: O Yes O No
Do you live with or have you lived with someone who smokes: O Yes O No

Do you use illegal drugs: O Yes O No If yes, what types: _____
If yes, how often: _____ How much: _____

Do you currently drink alcohol: O Yes O No If yes, how much, how often: _____
If no, any past alcohol use: O Yes O No If yes, how much, how often: _____

Who lives with you: _____ Who helps you: _____
Do you need help with your daily activities? O Yes O No If yes, which activities: _____
Do you drive: O Yes O No

**FAMILY HISTORY:** Have any members of your family ever had any of the following?

| | Family Member | Type of Cancer / Description |
|---|---|---|
| Cancer | _____ | _____ Age at diagnosis: _____ |
| | _____ | _____ Age at diagnosis: _____ |
| | _____ | _____ Age at diagnosis: _____ |
| | _____ | _____ Age at diagnosis: _____ |
| Autoimmune Disease | _____ | _____ |
| (Rheumatoid arthritis, lupus | _____ | _____ |
| Sarcoidosis, scleroderma) | | |
| Diabetes | _____ | _____ |
| | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| | _____ | _____ |
| Heart Disease | _____ | _____ |
| | _____ | _____ |

**REPRODUCTIVE HISTORY – MEN ONLY**

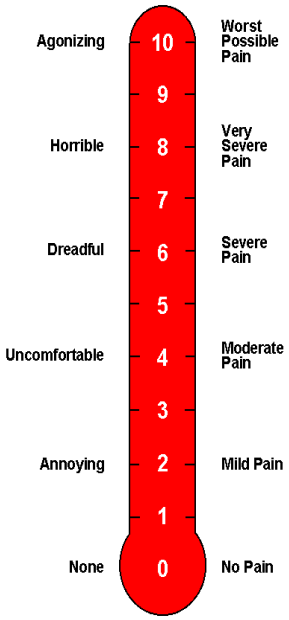
Are you sexually active: O Yes O No Any changes in your sexual function since your illness: O Yes O No
If yes, please describe: _____
Have you ever taken any hormonal therapy (such as Lupron): O Yes O No Date of last dose: _____
Do you have hot flashes: O Yes O No

**REPRODUCTIVE HISTORY – WOMEN ONLY**

Are you sexually active: O Yes O No Any changes in your sexual function since your illness: O Yes O No
If yes, please describe: _____
Total # of pregnancies: _____ Live Births: _____ Miscarriages: _____
Age at first pregnancy: _____ Age at first live birth: _____
Did you breast feed? O Yes O No If yes, how long? _____
Age at first menstrual period: _____ Age of last period: _____ Date of last menstrual period: _____
Have you ever taken birth control pills: O Yes O No If yes, how long: _____
Are you currently using any birth control method? O Yes O No If yes, which method: _____
**ANY CHANCE YOU COULD BE PREGNANT: O YES O NO**
Do you have regular pelvic exams? O Yes O No Date of last pelvic exam? _____
Have you ever used hormone replacement therapy (such as Premarin): O Yes O No
If yes, how long: _____ When did you stop taking hormones: _____
Have you ever taken fertility drugs? O Yes O No
Do you perform self-breast exams? O Yes O No What size bra do you wear? (ex 36C) _____
Do you have breast implants? O Yes O No Have you had a breast reduction? O Yes O No
How many breast biopsies have you had? _____ What were the results? _____
Are you of Ashkenazi-Jewish heritage? O Yes O No
Have you ever had BRCA or other genetic testing? O Yes O No If yes, were your results positive or negative? _____

**PAIN HISTORY**

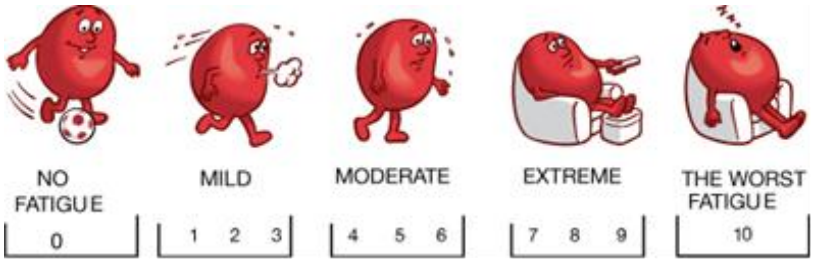
Do you have pain? O YES O NO
If yes, where is the pain: _____
On a scale of 0 to 10, how would you rate your pain? _____




**FATIGUE HISTORY**

Do you feel so tired that you cannot do everyday things?
O ALWAYS O SOMETIMES O NEVER
Do you have trouble sleeping: O Yes O No
Do you nap through the day: O Yes O No

On a scale of 0 to 10 (0 = no fatigue, 10 = worst fatigue),
How would you rate your fatigue: _____




Which activities cause your pain to increase: _____
What gives you relief from pain: _____
Does pain prevent you from pursuing normal activities: O Yes O No

**Circle YES or NO if you have any RECENT problems related to the following systems:**

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | YES | NO |
| Chills | YES | NO |
| Night Sweats | YES | NO |
| Weight Loss | YES | NO |
| Weight before illness: _____ | | |
| Excessive Fatigue | YES | NO |
| Other: _____ | | |

**Eyes**

| | | |
|---|---|---|
| Blurred Vision | YES | NO |
| Double Vision | YES | NO |
| Eye Pain | YES | NO |
| Excessive Tearing | YES | NO |
| Other: _____ | | |

**Allergic/Immunologic**

| | | |
|---|---|---|
| Hay Fever | YES | NO |
| Other: _____ | | |

**Neurological**

| | | |
|---|---|---|
| Tremors | YES | NO |
| Dizzy Spells/Fainting | YES | NO |
| Numbness/Tingling | YES | NO |
| Headache | YES | NO |
| Seizures | YES | NO |
| Weakness | YES | NO |
| Other: _____ | | |

**Gastrointestinal**

| | | |
|---|---|---|
| Heartburn | YES | NO |
| Vomiting/Nausea | YES | NO |
| Early Fullness when eating | YES | NO |
| Abdominal Pain | YES | NO |
| Diarrhea | YES | NO |
| Constipation | YES | NO |
| Bleeding from rectum | YES | NO |
| Hemorrhoids | YES | NO |
| Black/Tarry Bowel Movements | YES | NO |
| Irregular Bowel Movements | YES | NO |
| How so: _____ | | |
| Change in Bowel Pattern | YES | NO |
| How so: _____ | | |

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | YES | NO |
| Persistent Itch | YES | NO |
| Hives | YES | NO |
| Other: _____ | | |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | YES | NO |
| Neck Pain | YES | NO |
| Back Pain | YES | NO |
| Other: _____ | | |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear Infection | YES | NO |
| Sore Throat | YES | NO |
| Sinus Problems | YES | NO |
| Hearing Loss | YES | NO |
| Difficulty Swallowing | YES | NO |
| Change in Voice | YES | NO |
| Pain with Chewing | YES | NO |

**Endocrine**

| | | |
|---|---|---|
| Excessive Thirst | YES | NO |
| Too Hot / Too Cold | YES | NO |
| High Sugar / Diabetes | YES | NO |
| Other: _____ | | |

**Urinary**

| | | |
|---|---|---|
| Blood in Urine | YES | NO |
| Awaken at Night to Urinate | YES | NO |
| If yes, how many times: _____ | | |
| Bladder / Kidney Infections | YES | NO |
| Problems with Urine Control | YES | NO |
| Weak Stream | YES | NO |
| Other : _____ | | |

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | YES | NO |
| High Blood Pressure | YES | NO |
| Palpitation | YES | NO |
| Edema/Swelling | YES | NO |
| Other: _____ | | |

**Hematologic / Lymphatic**

| | | |
|---|---|---|
| Bruising | YES | NO |
| Swollen Glands | YES | NO |
| Blood Clotting Problems | YES | NO |
| Excessive Bleeding | YES | NO |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | YES | NO |
| Frequent Cough | YES | NO |
| Shortness of Breath | YES | NO |
| Blood with Coughing | YES | NO |

**Gynecology**

| | | |
|---|---|---|
| Abnormal/Irregular Bleeding | YES | NO |
| Vaginal Discharge | YES | NO |
| Vaginal Dryness | YES | NO |
| Painful Sexual Relations | YES | NO |
| Pelvic Pain / Pressure | YES | NO |
| Hot Flashes | YES | NO |
| Urinary Incontinence | YES | NO |
| Breast Pain / Lump / Discharge | YES | NO |

**Psychological**

| | | |
|---|---|---|
| Are you generally satisfied with your life? | YES | NO |
| Do you feel severely depressed? | YES | NO |

**Do you use any complementary therapies, such as acupuncture, massage, reiki, homeopathic**

O Yes Type: _____

O No

**ADVANCED DIRECTIVES/MOLST**

| | | |
|---|---|---|
| Do you have any Advanced Directives (Living Will, Durable Power of Attorney)? (If yes, please bring a copy with you for your chart.) | O Yes | O No |
| Do you have a MOLST Form (Medical Orders for Life-Sustaining Treatment)? (If yes, please bring a copy with you for your chart.) | O Yes | O No |
| Would you like information or assistance regarding Advanced Directives? | O Yes | O No |

**DOMESTIC VIOLENCE**

| | | |
|---|---|---|
| Are you afraid or have you been threatened by a current or former partner? | O Yes | O No |
| Within the past year, have you been hit, slapped, choked, forced into sexual activity or otherwise hurt by a current partner or family member? | O Yes | O No |
| Would you like to meet with our Domestic Violence Coordinator? | O Yes | O No |

**HOME MEDICATION LIST**

Please list all **CURRENT** medications, herbal supplements and over the counter drugs you are taking

| Date Prescribed | Physician Who Prescribed the Medication | Name of Medication or Supplement | Dose | Frequency You are Taking Medication | Date Stopped |
|---|---|---|---|---|---|
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