

**Huntsman Cancer Institute Gastrointestinal Cancer Program
 New Patient Data**

PLEASE fill in BEFORE YOUR APPOINTMENT. Your answers will help our staff plan and provide you with the best care, as well as help our research to better understand the risk factors for cancer. Leave blank any information that you are unsure of, or do not wish to answer. We will review the form with you.
Any information we gather will be kept confidential. PRINT AND USE INK. Thank you.

History of Present Illness

Problem or Diagnosis (Why are you here?): _____
 Start Date of symptoms or 1st Diagnosis: _____

Studies Completed Before This Visit:

- | | |
|---------|---------|
| ▪ _____ | ▪ _____ |
| ▪ _____ | ▪ _____ |
| ▪ _____ | ▪ _____ |
| ▪ _____ | ▪ _____ |

Current Symptoms or Problems:

Past Medical History

Other Medical Conditions:

Year of Onset:

- | | |
|---------|-------|
| ▪ _____ | _____ |
| ▪ _____ | _____ |
| ▪ _____ | _____ |
| ▪ _____ | _____ |
| ▪ _____ | _____ |
| ▪ _____ | _____ |
| ▪ _____ | _____ |

Have you had any of the following illnesses? Please check ALL that apply.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Colitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other: _____ |

Please complete the **TABLE** below for **PRIOR** cancer, radiation treatment, or chemotherapy that you may have had:

	Don't Know	No	Yes	Year	Kind of cancer or type of disease/condition
Prior Cancers (before current illness):					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy:					

Patient Demographics

Patient Name: _____
 Gender: Male Female
 Race: _____ Ethnicity: _____

Today's Date: ____/____/____
 Date of Birth: ____/____/____

Person Completing This Form: _____
 Patient Other (Please Indicate Relationship) _____

Primary Language: English Spanish Other: _____ Needs Certified Translator

Address: _____

Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 *Please star preferred contact number

Emergency Contact Information

Name: _____
 Relationship: _____
 Phone: _____ Type: _____
 Phone: _____ Type: _____

For patients traveling to the Huntsman Cancer Center please indicate where you can be reached locally: (i.e. Hotel Room, Relative's, Friend's, etc.)

I will be staying: _____
 Local Phone Number: _____

Insurance

Insurance #1: _____ Address: _____ _____ Phone: _____	Subscriber: _____ Subscriber Date of Birth: ____/____/____ Policy #: _____ Group #: _____
Insurance #2: _____ Address: _____ _____ Phone: _____	Subscriber: _____ Subscriber Date of Birth: ____/____/____ Policy #: _____ Group #: _____

Physicians Involved in Your Care

Specialty	First Name	Last Name	Address	Phone
Referring Physician				
Primary Care Physician				
Surgeon				
Medical Oncologist				
Radiation Oncologist				
Gastroenterologist				
Interventional Radiologist				
Other				

Family Medical History

Have any family members had any of the following (please check **ALL** that apply):

Disease	What Relative?	What Age?
<input type="checkbox"/> Heart Disease		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Lung Disease		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Thyroid Disease		
<input type="checkbox"/> Bleeding Tendency		
<input type="checkbox"/> Inflammatory Bowel Disease		
<input type="checkbox"/> Crohn's Disease		
<input type="checkbox"/> Ulcerative Colitis		
<input type="checkbox"/> Anesthesia Difficulties		
<input type="checkbox"/> Cancers (Please List Type)		
<input type="checkbox"/> Other(s)		

Excluding yourself, how many of each of the following blood-related members do you have?
Remember to include those who are no longer living. Include only **FULL** brothers or sisters.

Brothers _____ Sisters _____ Sons _____ Daughters _____

Social History

Where were you born? City _____ State _____ Country _____
 In what City, State, and Country have you lived the longest? _____

Alcohol History:

Do you drink alcoholic beverages regularly (at least 1 drink per month)?
 Yes, currently Yes, but quit Never/Rarely

Complete the table below if you checked **EITHER** Yes box to the alcohol question above:

Beverage	Number of Drinks Per:				Number of Years
	Day	Week	Month	Year	
Beer (12 of can/bottle)					
Wine (4 oz. glass)					
Liquor (1 shot or jigger)					

If you have quit drinking, how old were you when you quit? _____ years old

Tobacco History:

Do you currently or have you ever smoked?

Yes, currently Yes, but quit smoking When? _____ No

How old were you when you first started smoking cigarettes regularly? _____ years old

On average, how many cigarettes do/did you smoke per day? _____ cigarettes per day

Have you ever used any of the following tobacco products?

	Yes	No	Quit	Year Quit	Amount/Day	Years Used
Chewing Tobacco						
Snuff or Dip						
Pipes						
Cigars						

Have you ever used any recreational (street) drugs? Yes, currently Yes, in past Never

If you answered Yes to the above question, please describe:

Marital Status: Single Married Widowed Divorced

Work History:

Are you currently able to work? Yes, Full-Time Yes, Part-Time No Retired Not Applicable

What is your current job? _____

If you are *unable* to work, when were you last able to work? _____

Have you applied for disability? Yes No If yes, effective date: _____

List any hazardous substances you may have been exposed to as a result of your current or past job(s):

When were you last immunized for:

Immunization	Date
Influenza "Flu Shot"	
Pneumovax	
Tetanus	
Chickenpox	
MMR	
When were you last tested for TB? What was the result? _____	

Review of Symptoms (Please check all that apply to you)

General Symptoms	<input type="checkbox"/> Fatigue <input type="checkbox"/> Malaise <input type="checkbox"/> Other: _____	<input type="checkbox"/> Fever <input type="checkbox"/> None	<input type="checkbox"/> Weight Loss Amount _____	<input type="checkbox"/> Weight Gain Amount _____
Eyes	<input type="checkbox"/> Painful Eyes <input type="checkbox"/> Change in Vision <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dry Eyes <input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> None
Ears, Nose, & Throat	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Hay Fever <input type="checkbox"/> Deafness <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Lump or Mass in Neck/Throat <input type="checkbox"/> Toothache <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Dry Mouth <input type="checkbox"/> Difficult Chewing <input type="checkbox"/> Difficult Swallowing <input type="checkbox"/> None
Heart/Blood Vessels	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Chest Pressure <input type="checkbox"/> Murmur <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last EKG: _____ <input type="checkbox"/> Prior Heart Studies (ex. Treadmill/ECHO/Angiography): _____	<input type="checkbox"/> Palpitations <input type="checkbox"/> Racing Heart <input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Swelling Feet/Legs <input type="checkbox"/> Waking up Short of Breath <input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Pain in Legs from Walking <input type="checkbox"/> None
Lungs	<input type="checkbox"/> Sputum/Phlegm <input type="checkbox"/> Wheezing <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last Chest X-Ray: _____	<input type="checkbox"/> Shortness of Breath at Rest	<input type="checkbox"/> Shortness of Breath w/ Exertion	<input type="checkbox"/> Cough <input type="checkbox"/> None
Stomach & Intestines	<input type="checkbox"/> Change in Appetite <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last Endoscopy: _____ <input type="checkbox"/> Last Colonoscopy: _____	<input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Black Stools <input type="checkbox"/> None
Kidneys & Bladder	<input type="checkbox"/> Difficulty with Urination <input type="checkbox"/> Urine Leakage <input type="checkbox"/> Other: _____	<input type="checkbox"/> Arising at Night to Urinate <input type="checkbox"/> Urine Urgency	<input type="checkbox"/> Pain or Burning on Urination <input type="checkbox"/> Blood in Urine	<input type="checkbox"/> History of Kidney Stones <input type="checkbox"/> None
Muscle & Skeleton	<input type="checkbox"/> Muscle Pain <input type="checkbox"/> Joint Pain (which): _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Back Pain	<input type="checkbox"/> None
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Bumps/New Moles <input type="checkbox"/> Other: _____	<input type="checkbox"/> Abnormal Growths	<input type="checkbox"/> Open Sores	<input type="checkbox"/> None
Brains & Nerves	<input type="checkbox"/> Weakness <input type="checkbox"/> Fainting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tremor <input type="checkbox"/> Headache	<input type="checkbox"/> Numbness <input type="checkbox"/> Depression	<input type="checkbox"/> Un-coordination <input type="checkbox"/> Anxiety <input type="checkbox"/> None
Glands	<input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Nighttime Sweats <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> None
Breasts/Chest	<input type="checkbox"/> Pain <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last Mammogram: _____	<input type="checkbox"/> Lump/Mass	<input type="checkbox"/> Nipple Retraction	<input type="checkbox"/> Discharge <input type="checkbox"/> None
Male Sexuality	<input type="checkbox"/> Impotence <input type="checkbox"/> Inability to Ejaculate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last Prostate Exam: _____	<input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Problems Passing Urine	<input type="checkbox"/> Pain w/ Intercourse <input type="checkbox"/> No Sexual Interest	<input type="checkbox"/> None
Female Sexuality	<input type="checkbox"/> Pain w/ Intercourse <input type="checkbox"/> No Sexual Interest <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Other: _____ <input type="checkbox"/> Last PAP smear: _____	<input type="checkbox"/> Abnormal Vaginal Bleeding or Discharge	<input type="checkbox"/> None	

Pain

In the last week have you been experiencing pain? Yes No (if no, skip to the next section)

If yes, where? _____

During the last week how often did you experience pain?

All the time Most of the time Half of the time Occasionally

Using the reporting scale below, **CIRCLE** the number that best indicates your response to the questions:

In the last week how much pain have you been experienced?

1	2	3	4	5	6	7	8	9	10
Very Little Pain									Worst Possible Pain

How much did the pain bother you?

1	2	3	4	5	6	7	8	9	10
Very Little									Extremely Bothered

To what extent has the pain affected:

Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Limited a lot Limited a little Not limited at all

Climbing a flight of stairs

Limited a lot Limited a little Not limited at all

Activity

On this scale 100 is "perfect" health and 0 is death (please select the one that is applicable to you)

- 100% (normal, no complaints, no signs of disease)
- 90% (capable of normal activity, few symptoms or signs of disease)
- 80% (normal activity with some difficulty, some symptoms or signs)
- 70% (caring for self, not capable of normal activity or work)
- 60% (requiring some help, can take care of most personal requirements)
- 50% (requires help often, requires frequent medical care)
- 40% (disabled, requires special care and help)
- 30% (severely disabled, hospital admission, requires supportive measure or treatment)
- 20% (very ill, urgently requiring admission, requires supportive measures or treatment)
- 10% (moribund, rapidly progressive fatal disease processes)
- 0% (death)

Fall Risk:

Do you ever experience dizziness or vertigo? Yes No

Have you fallen in the last 3 months? Yes No

Have you ever soiled (wet) yourself on your way to the bathroom? Yes No

Nutrition

Have you lost weight in the last month? No Yes How much? _____ was it intentional? No Yes

Have you unintentionally gained weight within the last 6 months? No Yes How much? _____

Have you unintentionally gained weight within the last 12 months? No Yes How much? _____

Have you had a change in appetite? No Yes (if yes, please describe):

Have you had a change in your food intake? No Yes (if yes, please describe):

Patient Needs

Emotional Needs Assessment:

Illness can be life changing. We want to know the areas where you feel you may need assistance.

Step 1: Please circle the number (0-10) on the scale below that best describes how much distress* you felt during the past week.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

High Distress (8-10): Overwhelming panic, despair, hopelessness.

Moderate Distress (5-7): Worry, fear, sadness that interfere with daily activities and treatment.

Low Distress (0-4): Worry, sadness, or fears that are mild and manageable.

*Distress is a normal part of having a serious illness. Certain signs or symptoms are a "red flag" that distress is becoming excessive. These may include feeling overwhelmed by fears to the point of panic or an overpowering sense of dread; feeling despair and hopelessness, or having constant thoughts about the illness.

Step 2: Check the causes of your distress in the list below. Only check the boxes that are causing you distress.

<p>Emotional Concerns:</p> <input type="checkbox"/> Worry <input type="checkbox"/> Sadness <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<p>Family Concerns:</p> <input type="checkbox"/> Dealing with Partner <input type="checkbox"/> Dealing with Children <input type="checkbox"/> Poor Support System	<p>Physical Concerns:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Bathing/Dressing <input type="checkbox"/> Nausea <input type="checkbox"/> Body Image <input type="checkbox"/> Sexual Problems
<p>Practical Concerns:</p> <input type="checkbox"/> Housing <input type="checkbox"/> Financial/Insurance <input type="checkbox"/> Work <input type="checkbox"/> Transportation	<p>Spiritual Concerns:</p> <input type="checkbox"/> No Spiritual Support <input type="checkbox"/> Other <hr/> <hr/>	<p>Any Other Concerns:</p> <hr/> <hr/> <hr/>

I would like to see a Social Worker

Wound/Ostomy:

- I have had my ostomy less than 1 month
- I have had my ostomy greater than 1 month and request a WOC nurse visit
- I have an open wound or skin problem
- Other: _____
- I would like to see a wound/skin/ostomy nurse for: _____

Religious Practices:

- I have religious practices/spiritual concerns that you should be aware of:

- I would like a visit from the Chaplain

Home Health Care:

- I have Home Health Care needs (IV therapy, nursing care, supplies, and medical equipment)
- Other: _____
- I would like to see a case manager

 Physician's Signature

 Date