AUSTIN CYBERKNIFE

A department of Dell Seton Medical Center at The University of Texas

PATIENT INTAKE FORM

Patient Name:		Today's Date:
Date of Birth:	Age:	Sex: Male Female
Drug Allergies: □ Yes □ No Please allergies and reactions: **Do you have any Implanted Devices:** □ Pacemaker □Defibrillator □Port-A-Cath □Other:		

Medical History

(Please list dates of each instance)

Major Medical Problems (i.e. Diabetes, Heart Problems, etc)	**Surgeries** (Please list approximate dates and Surgeon name)	**Hospitalizations** (Please list approximate dates)

Current Medications

(Include vitamins and/or herbal products)

Name of Medication	Dose	Frequency

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Social History

Marital status: □ Single □ Married □ Divorced □ Other:	Number of people in household:	
Maiden Name:	# of Children:	Ages of Children:
Citizenship/Country		
Are you currently employed? □ Yes □ No □ Retired		
Occupation (current or former):		
Living Will? □ Yes □ No	Religious Preference:	
Designated Power of Attorney? □ Yes □ No If yes, Name/Phone #:		
Organ donor? □ Yes □ No If yes, please have receptionist copy your card.		
Do you now or have you ever smoked? □ No □ Yes, I started at age_____, quit at age _____ □ Cigarettes,_____packs per day □ Other tobacco,_____packs per day Do you want information on smoking cessation? □Yes □ No	Do you drink alcohol? □ No □ Yes, please check a box below: **Women**: □ < 7 per week □ > 7 per week □ < 3 drinks/occasion □ > 3 drinks/ooccasion **Men**: □ < 14 per week □ > 14 per week □ < 4 drinks/occasion □ > 4 drinks/occasion	
Have you been treated for drug/alcohol abuse? □Yes □ No		
Have you been exposed to hazardous materials? □Yes □ No If yes, please describe:		

Family History

Is there a history of cancer in your family? □ No □ Yes, please list below:	
Relationship	**Type of Cancer**

Treatment Options

Have you had past experience with cancer? □ No □ Yes, type of cancer _____ When were you diagnosed? _____	Have you ever had chemotherapy? □ No □ Yes, in year _____
Have you ever received radiation therapy? □ No □ Yes, what part of your body?_____when? _____ At what institute/hospital?	

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Pain Assessment	
Are you having any pain? □ No □ Yes	Where is your pain?
Describe your pain (sharp, dull, stabbing, achy):	What activity causes your pain?
On the following scale, circle your pain. 0 (no pain)1----------2----------3----------4----------5----------6----------7----------8----------9---------10 (worst pain ever)	

Screenings (When were your most recent screening tests?)			
Type	**Date** **(please list approximate dates)**	**Results**	**Report Received**
Lipid (Cholesterol screening)			□
PSA (Prostate Cancer screening)			□
Stool test for occult blood			□
Sigmoidoscopy/Colonoscopy			□
Mammogram			□
Ever abnormal?			□
Pap Smear			□
Ever abnormal?			□
DEXA scan (osteoporosis screening)			□

Immunizations (When were your most recent immunizations?)			
□ Hepatitis A Date:	□ Influenza (flu shot) Date:	□ Measles Date:	□ Pneumovax Date:
□ Tetanus Date:	□ Varicella (chicken pox) Date:	□ Rubella Date:	

For office use only:

Grade	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.
5	Dead

Patient Signature:_____ **Date:** _____

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DEMOGRAPHIC INFORMATION

LAST NAME		FIRST NAME M.I.		TODAY'S DATE
HEIGHT	WEIGHT	AGE	DATE OF BIRTH	SEX (circle) Male/Female
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE		WORK PHONE	
PREFERRED NUMBER TO CALL MAY WE LEAVE A MESSAGE Y □ N □		SOCIAL SECURITY NUMBER		
E-MAIL ADDRESS May we use e-mail to communicate with you? Y □ N □				
CONTACT PERSON / RELATIONSHIP			PHONE NUMBER	
CONTACT PERSON ADDRESS, CITY, STATE, ZIP			PHONE NUMBER	
EMERGENCY CONTACT SAME AS ABOVE □			PHONE NUMBER	
PATIENT EMPLOYER			OCCUPATION	
EMPLOYER ADDRESS, CITY, STATE, ZIP			PHONE NUMBER	
SPOUSE/PARENT NAME	RELATION TO PATIENT		SSN#	
SPOUSE/PARENT EMPLOYER			OCCUPATION	
SPOUSE/PARENT EMPLOYER		PHONE NUMBER/CITY/STATE/ZIP		
HOW WERE YOU REFERRED TO US? (Circle all that apply) MD TV WEB RADIO BILLBOARD PRINT FAMILY/FRIEND NEWS STORY/ARTICLE				
PRIMARY PHYSICIAN		PHONE NUMBER/CITY/STATE/ZIP		
REFERRING PHYSICIAN		PHONE NUMBER/CITY/STATE/ZIP		
MEDICAL ONCOLOGIST		PHONE NUMBER/CITY/STATE/ZIP		
RADIATION ONCOLOGIST		PHONE NUMBER/CITY/STATE/ZIP		
SURGEON		PHONE NUMBER/CITY/STATE/ZIP		
OTHER PHYSICIANS		PHONE NUMBER/CITY/STATE/ZIP		
OTHER PHYSICIANS		PHONE NUMBER/CITY/STATE/ZIP		

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PATIENT INSURANCE INFORMATION

Please fill out the following information and have your insurance card and photo ID available as the receptionist will be making a copy. Thank You.

Primary Insurance:	Primary Insurance Phone Number:
Subscriber:	Subscriber Date of Birth:
Subscriber Social Security Number:	Patient's Relationship to Subscriber:
Primary Policy Number	Primary Group Number
Secondary Insurance:	Secondary Insurance Phone Number:
Subscriber:	Subscriber Date of Birth:
Subscriber Social Security Number:	Patient's Relationship to Subscriber:
Secondary Policy Number	Secondary Group Number
Third Insurance:	Third Insurance Phone Number:
Subscriber:	Subscriber Date of Birth:
Subscriber Social Security Number:	Patient's Relationship to Subscriber:
Third Policy Number	Third Group Number

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REVIEW OF SYSTEMS

Eyes	Y	N
Near-sighted		
Far-sighted		
Do you wear contacts?		
Glaucoma		
Cataracts		
Eye pain		
Double vision		
Floating lights		
Excessive tearing		
Blurry Vision		
Immunology	**Y**	**N**
Rheumatoid arthritis		
Lupus		
Scleroderma		
Gastrointestinal	**Y**	**N**
Chronic abdominal pain		
Persistent nausea/vomiting		
Heartburn		
Appetite loss		
Vomiting blood		
Diarrhea		
Blood/clay-colored stools		
Hemorrhoids		
Constipation		
Hepatitis		
Gall bladder disease		
Difficulty swallowing		
Genitourinary	**Y**	**N**
Excessive dribbling		
Burning upon urination		
Incontinence		
Frequent urination at night		
Blood in urine		
Kidney stones		
Reproductive – Male	**Y**	**N**
Discharge/sore penis		
Hernias		
Testicular pain or lumps		
History of venereal disease		
Type:		
Sexually active		
Endocrine	**Y**	**N**
Thyroid trouble		
Hot/cold intolerance		
Excessive thirst/hunger		
Diabetes, if yes, on insulin?		
Musculoskeletal	**Y**	**N**
Numbness in arms or legs		
Tingling in arms or legs		
Problems walking		
Muscle jerking		
Paralysis		
Shaking/tremors		
Limited motion		
Muscle pain		
Psychiatric	**Y**	**N**
Depression		
Anxiety		
On psychiatric medicine?		

Has patient fallen in the last year?

YES OR NO

Does the patient use assistive devices to walk/get around?

YES OR NO

Nurse:

Date:

Ears/Nose/Throat/Mouth	Y	N
Hearing loss		
Ringing in ears		
Pain in ears		
Discharge from ear		
Chronic nose obstruction		
Repeated nosebleeds		
Persistent sore gums		
Dentures		
Prolonged hoarseness		
Dry mouth		
Respiratory	**Y**	**N**
Chronic cough		
Difficulty breathing		
Asthma		
Emphysema		
Bronchitis		
Sit up to breathe easier?		
Wheezing		
Tuberculosis		
Pneumonia		
Require oxygen? l/min		
Coughing up blood		
Skin	**Y**	**N**
Lumps or bumps?		
Color change in moles		
Hives or rashes		
Psoriasis/eczema		
Prior skin cancer		
Shingles		
Neurological	**Y**	**N**
Dizziness/fainting		
Memory loss		
Seizures		
Speech changes		
Sensory loss or changes		
Weakness in arms or legs		
Reproductive – Female	**Y**	**N**
Breast lumps		
Nipple discharge		
Hormone therapy		
Last menstrual period / /		
Sexually active		
History of venereal disease		
Type:		
Cardiovascular	**Y**	**N**
High blood pressure		
Heart disease or defects		
Pacemaker		
Defibrillator		
Swelling of legs		
Chest pain		
Hemo/lymphatic	**Y**	**N**
Anemia		
Bruising/bleeding		
Swollen lymph nodes		
HIV positive		
If yes, diagnosis date: / /		
Night sweats		
Frequent infections		
Allergies	**Y**	**N**
Hay fever		
Molds		