UNC Cancer Care

New Patient Information Form

UNC HEALTH CARE
UNC CANCER CARE

Welcome to the N. C. Cancer Hospital. We are pleased that you have chosen UNC for your cancer care. To provide you the best possible care, we would like to know more about you and your health. After filling out this form, return it to the staff member at the clinic check-in desk where you are being seen.

What is your name? _____

What name do you like to be called? _____

What email address would you like us to use? _____

Which pharmacy do you use (name, location, and phone number)? _____

_____

Who is your regular doctor (name, location and phone number)? _____

_____

What is the reason for your visit today? _____

_____

Tell us about your health. Please write the year you were diagnosed for any of the following:

	Year		Year		Year
High blood pressure	_____	Tuberculosis (TB)	_____	Osteoporosis	_____
High cholesterol	_____	COPD /Emphysema	_____	Low Vitamin D	_____
Heart attack	_____	Liver disease	_____	Skin problems	_____
Heart failure	_____	Kidney problems	_____	HIV/AIDS	_____
Other heart problems	_____	Gall bladder problems	_____	Cancer	_____
Bleeding problems	_____	Stomach ulcers	_____	Stroke	_____
Blood clots	_____	Diabetes	_____	Seizures	_____
Anemia	_____	Thyroid problems	_____	Migraines	_____
Lung problems	_____	Arthritis	_____	Depression	_____
Asthma	_____	Broken Bones	_____	Anxiety	_____

Please tell us about any other health problems or concerns you have:

_____

_____

_____

Have you ever had surgery?

Type of Surgery Year Done

1. _____

2. _____

3. _____

4. _____

Have you been exposed to radiation, including radiation treatments or multiple x-rays: _____

_____

Tell us about your family. List any health problems, including any types of cancer, and age he/she was diagnosed.

Mother: _____

Father: _____

Children: _____

Grandparents: _____

Other: _____

Tell us about any medicines that you take. Include prescription, over the counter medicines, vitamins, and herbs.

Or you can bring all of the bottles of medicine that you take to your visit and skip this part.

Name of Medicine, Vitamin, Herb or Supplement	Dose	How often do you take?

Do you have any allergies to food, medicines, or latex? If yes, tell us what happens when you take them.

Allergy:	What happens:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Are you: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ In a committed relationship

Who lives with you ?_____

_____

Please circle your answer for these questions:

- Do you use illegal ("recreational") drugs? Yes No

  If yes, what type of drug? _____

  How often are using this drug? _____

- Do you drink alcohol? Yes No

  If yes, how many drinks per week? _____

- Do you exercise? Yes No

  If yes, how often and what type? _____

- Do you drink caffeine (coffee/soft drinks)? Yes No

  If yes, how many cups per day? _____

- Do you work? Yes No

  If yes, what is your job? _____

- Have you ever used any type of tobacco (cigarettes, pipes, cigars, chewing tobacco)? Yes No

  If yes: What kind? _____ How many per day? _____

- Do you smoke or use other types of tobacco now? Yes No

- Are you ready to quit in the next 30 days? Yes No Not Sure

For Women: Are you still having periods? Yes No

If yes: When was your last period? _____

Are you or could you be pregnant? _____

If no: When did you stop having periods? _____

Do you have any of the following? Check all that apply:

❑ Fever/chills	❑ Ear pain	❑ Nausea/vomiting
❑ Fatigue	❑ Headaches	❑ Diarrhea or constipation
❑ Weight Loss/gain	❑ Numbness/tingling	❑ Stomach pain
❑ Trouble concentrating	❑ Loss of balance	❑ Problems urinating
❑ Trouble sleeping	❑ Weakness	❑ Blood in urine or stool
❑ Sweating episodes	❑ Heart problems	❑ Easy bruising or bleeding
❑ Pain (any area)	❑ Chest pain	❑ Swelling in arms or legs
❑ Vision changes	❑ Heart skipping beats or racing	❑ Bone or joint pain
❑ Mouth or throat pain	❑ Shortness of breath	❑ Skin rash
❑ Trouble swallowing/hoarse	❑ Cough	❑ New lump (any area)

Do you need help walking? _____

Do you use a cane, walker, or wheelchair to help with getting around? _____

Have you ever fallen because you lost your balance? _____

Are you having any other symptoms that are not listed above? _____

_____

_____

Please circle your answer these questions:

Do you have a living will?	Yes	No	Not Sure
Do you have a health care power of attorney?	Yes	No	Not Sure
Would you like to learn more about these?	Yes	No	

Notes:

_____

_____

_____

_____

_____