



Chattanooga's Program In Women's Oncology  
Comprehensive Cancer Care for Women  
*Let us guide you through your storm.*

102 Central Avenue  
Chattanooga, Tennessee 37403  
Phone: (423) 266-3636  
Fax: (423) 266-3633

## New Patient Intake Questionnaire:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Best Contact for You? \_\_\_\_\_

Home phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

e-Mail : \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Have you completed the form for:

Medical Record transfer? Y N

HIPPA form (Who can/can't give medical information to)? Y N

What Doctor referred you? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Why are you here today? \_\_\_\_\_

What are you hoping the doctor can do for you? \_\_\_\_\_

\_\_\_\_\_

Ht \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_ Age \_\_\_\_\_

Past Medical History:

Number of pregnancies \_\_\_\_\_

Number of children born alive \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Number of abnormal pregnancies \_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_

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Have you been diagnosed with a problem with:

|               |   |   |
|---------------|---|---|
| Head/Brain    | Y | N |
| Eyes/Glasses  | Y | N |
| Neck/Thyroid  | Y | N |
| Breast        | Y | N |
| Lungs         | Y | N |
| Heart         | Y | N |
| Abdomen       | Y | N |
| Legs/Arms     | Y | N |
| Skin          | Y | N |
| Pelvic Organs | Y | N |

Previous:

|                              |   |   |
|------------------------------|---|---|
| Cancer                       | Y | N |
| Heart Attack                 | Y | N |
| Hypertension                 | Y | N |
| Emphyema                     | Y | N |
| Stroke                       | Y | N |
| Blood clots                  | Y | N |
| Ulcer                        | Y | N |
| Herpes                       | Y | N |
| Abnormal vaginal bleeding    | Y | N |
| Sexually transmitted disease | Y | N |
| HIV                          | Y | N |

Last Test was? \_\_\_\_\_

When was your last;

|                   |                            |   |   |
|-------------------|----------------------------|---|---|
| Mammagram _____   | Has it ever been Abnormal? | Y | N |
| Pap Smear _____   | Has it ever been Abnormal? | Y | N |
| Colonoscopy _____ |                            |   |   |

Current Medication; \_\_\_\_\_

Allergies: \_\_\_\_\_

Please List all Surgery and date:

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Do you:

Use Tobacco: Y      N    How Much: \_\_\_\_\_ For How Long: \_\_\_\_\_

Drink Alcohol: Y      N    How Much: \_\_\_\_\_ How often: \_\_\_\_\_

Use Non prescription Drugs now: Y      N    In the Past: Y      N

Who do you live with?

Family History: (Please list relation date of their cancer and Type of cancer)

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Review of systems:

|                         |   |   |                            |   |   |
|-------------------------|---|---|----------------------------|---|---|
| Can you see             | Y | N | Frequent Urination         | Y | N |
| Do you hear normally    | Y | N | Blood in your urine        | Y | N |
| Are you short of breath | Y | N | Menstrual abnormalities    | Y | N |
| Do you have:            |   |   | To much bleeding           | Y | N |
| Abdominal pain          | Y | N | Bleeding between periods   | Y | N |
| Pelvic pain             | Y | N | Period lasting to long     | Y | N |
| Chest pain              | Y | N | Pelvic relaxation of       | Y | N |
| Nausea                  | Y | N | Bladder                    | Y | N |
| Vomiting                | Y | N | Vagina                     | Y | N |
| Constipation            | Y | N | Rectum                     | Y | N |
| Diarrhea                | Y | N | Do you sleep normally      | Y | N |
| Bowel movement changes  | Y | N | To much sleep              | Y | N |
| Blood in your stool     | Y | N | Unable to sleep            | Y | N |
| Vaginal bleeding        | Y | N | New skin rash/Irritation   | Y | N |
| Changes with urination: |   |   | Appetite Normal            | Y | N |
| Urinary Incontinence    | Y | N | Energy Level Normal        | Y | N |
| Painful urination       | Y | N | Sexual Function Normal     | Y | N |
|                         |   |   | Chages in Weight?          | Y | N |
|                         |   |   | How much? + _____ /- _____ |   |   |