

**NEW PATIENT QUESTIONNAIRE**  
**Advanced Oncology/Oregon Urology Institute P.C.**  
 1457 G Street, Springfield OR 97477 541-334-3351

\_\_\_\_\_  
 Name DOB Today's Date

\_\_\_\_\_  
 Diagnosis Referring Physician Primary Care Physician

\_\_\_\_\_  
 Reason for Today's Visit (In Your Own Words) e-mail address

Preferred Method for Receiving Reminders: E-mail  Cell Phone

**Current Medications**

| Medication | Dose / Frequency |
|------------|------------------|
|            |                  |
|            |                  |
|            |                  |
|            |                  |
|            |                  |
|            |                  |

| Medication | Dose / Frequency |
|------------|------------------|
|            |                  |
|            |                  |
|            |                  |
|            |                  |
|            |                  |
|            |                  |

**Preferred Pharmacy:** \_\_\_\_\_

**Preferred Laboratory:** \_\_\_\_\_

**Allergies to Medications** (List all including description of reaction):

\_\_\_\_\_  
 \_\_\_\_\_

**Date of your last Colonoscopy:** \_\_\_\_\_

**Are you at risk for falls:** \_\_\_\_\_

**Past Medical History** (Please mark only if you have a history of any of the following):

|                          |                                    |
|--------------------------|------------------------------------|
| <input type="checkbox"/> | Lupus                              |
| <input type="checkbox"/> | Scleroderma                        |
| <input type="checkbox"/> | Collagen Vascular Disease          |
| <input type="checkbox"/> | Urinary Retention /Catheterization |
| <input type="checkbox"/> | Implanted Pacemaker /Defibrillator |
| <input type="checkbox"/> | Sarcoid                            |
| <input type="checkbox"/> | Diabetes                           |
| <input type="checkbox"/> | Mental Health Issues               |
| <input type="checkbox"/> |                                    |
| <input type="checkbox"/> |                                    |

|                          |                            |
|--------------------------|----------------------------|
| <input type="checkbox"/> | Abnormal Heart Rhythm      |
| <input type="checkbox"/> | Alzheimer's                |
| <input type="checkbox"/> | Anemia                     |
| <input type="checkbox"/> | Asthma                     |
| <input type="checkbox"/> | Atrial Fibrillation (AFib) |
| <input type="checkbox"/> | Autoimmune Disorder        |
| <input type="checkbox"/> | Bipolar Disease            |
| <input type="checkbox"/> | Bladder Cancer             |
| <input type="checkbox"/> | Bleeding Disorder          |
| <input type="checkbox"/> | Brain Tumor                |
| <input type="checkbox"/> | Breast Cancer              |

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Cervical Cancer                              |
| <input type="checkbox"/> | Cirrhosis                                    |
| <input type="checkbox"/> | Clotting Disorder                            |
| <input type="checkbox"/> | Colon Cancer                                 |
| <input type="checkbox"/> | Congestive Heart Failure (CHF)               |
| <input type="checkbox"/> | COPD (Chronic Obstructive Pulmonary Disease) |
| <input type="checkbox"/> | Coronary Artery Disease                      |
| <input type="checkbox"/> | Crohn's Disease / Ulcerative Colitis (UC)    |

|  |
|--|
| Dementia   |
| Depression   |
| Diabetes – Type 1 (juvenile)                       |
| Diabetes – Type 2 (adult)                          |
| Dialysis   |
| Diverticulitis / Diverticulosis                    |
| DVT (Deep Vein Thrombosis, ie blood clots)         |
| Endometriosis                                      |
| Fibromyalgia                                       |
| GERD (Heartburn, Gastro-Esophageal Reflux Disease) |
| Glaucoma   |
| Head & Neck Cancer                                 |
| Heart Attack (MI, or Myocardial Infarct)           |
| Hepatitis  |
| High Blood Pressure (Hypertension, HTN)            |

|                                   |
|-----------------------------------|
| High Cholesterol (Hyperlipidemia) |
| Hypothyroidism                    |
| Incontinence                      |
| Infertility                       |
| Irritable Bowel Syndrome (IBS)    |
| Kidney Cancer                     |
| Kidney Disease                    |
| Kidney Stones                     |
| Leukemia                          |
| Liver Disease                     |
| Lung Cancer                       |
| Lymphoma                          |
| Multiple Sclerosis (MS)           |
| Myeloma                           |
| Neurologic Disorder               |
| Osteoarthritis                    |
| Osteoporosis                      |
| Ovarian Cancer                    |
| Pancreatitis                      |

|  |
|--|
| Parkinson’s Disease                      |
| Peripheral Vascular Disease              |
| Pneumonia                                |
| Prostate Cancer                          |
| Pulmonary Embolism (PE)                  |
| Rheumatoid Arthritis (RA)                |
| Schizophrenia                            |
| Seizure                                  |
| Obstructive Sleep Apnea (OSA)            |
| Spinal Cord Injury                       |
| Stroke (Cerebral Vascular Accident, CVA) |
| TIA (Transient Ischemic Attack)          |
| Thyroid Cancer                           |
| Gastrointestinal Bleeding (ulcer)        |
| Urinary Tract Infection (UTI)            |
| Valvular Heart Disease                   |

**Past Surgical History** (Please mark only if you have a history of any of the following):

|   |
|---|
| Prostatectomy                                   |
| TURP (Trans-Urethral Resection of the Prostate) |
| Nephrectomy (Removal of Kidney)                 |
| Orchiectomy (Removal of Testicle)               |
| Abdominoplasty / ‘Tummy Tuck’                   |
| Amputation                                      |
| Aneurysm Repair                                 |
| Angioplasty                                     |
| Antireflux Surgery                              |
| Aortic Bypass                                   |
| Appendectomy (Removal of Appendix)              |
| Arthroscopy                                     |
| AV Fistula                                      |
| Back Surgery                                    |
| Bladder Surgery                                 |

|  |
|--|
| Bowel Surgery                          |
| Bowel Obstruction                      |
| Brain Surgery                          |
| Breast Augmentation                    |
| Breast Reduction                       |
| Bronchoscopy                           |
| Carotid Endarterectomy                 |
| Carpal Tunnel                          |
| Coronary Stent / Heart Catheterization |
| C-Section                              |
| Defibrillator                          |
| Dialysis Catheter                      |
| Ear Tubes                              |
| Exploratory Laparotomy / Laparoscopy   |
| Gall Bladder Removal (Cholecystectomy) |
| Hernia Repair                          |
| Hip Replacement                        |
| Hysterectomy                           |

|   |
|---|
| Hysterectomy with Oophorectomy (Ovaries also removed) |
| Incontinence Surgery                                  |
| Knee Replacement Surgery                              |
| Laminectomy   |
| Liposuction   |
| Lumpectomy  |
| Lung Surgery  |
| Mastectomy  |
| Neck Surgery  |
| Pacemaker   |
| Peripheral Arterial Bypass                            |
| Repair of Fracture                                    |
| Shoulder Surgery                                      |
| Spinal Fusion   |
| Stomach Surgery                                       |
| Thyroid Surgery                                       |
| Tonsils   |

**Family History:**

| Family Member | Medical Problem(s) |
|---------------|--------------------|
| Father        |                    |

|                      |  |
|----------------------|--|
| Mother               |  |
| Maternal Grandmother |  |

|                      |  |
|----------------------|--|
| Paternal Grandmother |  |
| Maternal Grandfather |  |
| Paternal Grandfather |  |

|                |  |
|----------------|--|
| Siblings       |  |
| Brother/Sister |  |
| Brother/Sister |  |

## Social History:

### Smoking History:

|  |                |
|--|----------------|
|  | Current Smoker |
|  | Former Smoker  |
|  | Never Smoker   |

|                |  |
|----------------|--|
| # Years Smoked |  |
| # Packs / Day  |  |
| # Years Quit   |  |

### Alcohol History

|  |                       |
|--|-----------------------|
|  | Every Day             |
|  | Occasionally          |
|  | Quit / Former Drinker |
|  | Never                 |

|                |  |
|----------------|--|
| # Days / Week  |  |
| # Drinks / Day |  |
| # Years Quit   |  |

### Substance Use:

|  |                               |
|--|-------------------------------|
|  | Cigars                        |
|  | Chewing tobacco               |
|  | Beer                          |
|  | Illicit or recreational drugs |
|  | Narcotics                     |
|  | Marijuana                     |
|  | Liquor                        |
|  | Pipe smoking                  |
|  | Cigarettes                    |
|  | Wine                          |
|  | Snuff                         |

### Occupational Exposures:

|  |                          |
|--|--------------------------|
|  | Coal                     |
|  | Benzene                  |
|  | Asbestos                 |
|  | Lead                     |
|  | Mercury                  |
|  | Red Dye #3               |
|  | Radiation                |
|  | Other Petroleum Products |
|  | Xylene                   |
|  | Agent Orange             |

## Personal / Environment

### Support Systems

|  |   |
|--|---|
|  | Single  |
|  | Married   |
|  | Significant Other                                     |
|  | Divorced  |
|  | Widowed   |
|  | Live with spouse/significant other, family or friends |
|  | Live alone  |
|  | Live in Assisted Living environment                   |
|  | Live in Nursing Home                                  |
|  | Homeless  |
|  | Incarcerated  |
|  | No Transportation Difficulties                        |

|  |   |
|--|---|
|  | Will Need Transportation Assistance         |
|  | Family/Friends willing to assist with needs |
|  | No support system in place                  |
|  | Require Social Services for assistance      |

### Activities

|  |                      |
|--|----------------------|
|  | Employed – Full Time |
|  | Employed – Part Time |
|  | Unemployed           |
|  | Disabled             |
|  | Retired              |
|  | Sedentary            |

|  |                     |
|--|---------------------|
|  | Light Exercise      |
|  | Occasional Exercise |
|  | Regular Exercise    |
|  | Extensive Exercise  |
|  | Sexually Active     |
|  | Sexually Inactive   |

## Nutrition

|  |                         |
|--|-------------------------|
|  | Regular meals           |
|  | Nutritional Supplements |
|  | Vegetarian              |
|  | Liquid Diet             |
|  | Diabetic Diet           |

## Review of Systems:

### General/Constitutional

|  |   |
|--|---|
|  | Decreased appetite                          |
|  | Fatigue (physical)                          |
|  | Fever                                       |
|  | Lethargy (mental)                           |
|  | Night Sweats                                |
|  | Rigors / Shaking Chills                     |
|  | Weight Change<br>(+/- 10% of normal weight) |

### Head & Neck

|  |   |
|--|---|
|  | Hair Loss (Alopecia)                      |
|  | Blurry Vision                             |
|  | Double Vision                             |
|  | Watery Eyes (Lacrimation)                 |
|  | Visual Light Sensitivity<br>(Photophobia) |
|  | Visual Difficulties                       |
|  | Difficulty Swallowing<br>(Dysphagia)      |
|  | Epistaxis (Nose bleeds)                   |
|  | Esophagitis (Pain on<br>Swallowing)       |
|  | Difficulty Hearing                        |
|  | Dry Mouth                                 |
|  | Oral Bleeding                             |
|  | Ear Pain (Otalgia)                        |
|  | Sinusitis                                 |
|  | Mouth Sores (Stomatitis)                  |
|  | Altered Taste                             |
|  | ringing in Ears (Tinnitus)                |
|  | Neck Masses/Lumps                         |
|  | Neck Muscle Weakness                      |
|  | Neck Pain                                 |
|  | Decreased Range of<br>Motion in Neck      |
|  | Neck Swelling                             |

### Cardiovascular

|  |   |
|--|---|
|  | Irregular Heart Beat<br>(Arrhythmia)              |
|  | Chest Pain  |
|  | Swelling of Legs (Edema)                          |
|  | Shortness of Breath when<br>Lying Down(Orthopnea) |
|  | Palpitations                                      |

### Respiratory

|  |                                   |
|--|-----------------------------------|
|  | Cough                             |
|  | Shortness of Breath<br>(Dyspnea)  |
|  | Coughing up Blood<br>(Hemoptysis) |
|  | Sharp Pain with Breathing         |
|  | Wheezing                          |

### Gastrointestinal

|  |  |
|--|--|
|  | Abdominal Pain                                   |
|  | Change in Bowel Habits                           |
|  | Bright Red Blood in Stool                        |
|  | Constipation                                     |
|  | Dark Blood in Stool / GI<br>Bleeding             |
|  | Diarrhea   |
|  | Heartburn / reflux / GERD                        |
|  | Hemorrhoids                                      |
|  | Nausea   |
|  | Early Satiety (Can't eat<br>much in one sitting) |
|  | Vomiting   |
|  | Vomiting Blood                                   |

### Genitourinary

|  |                                |
|--|--------------------------------|
|  | Blood in Urine                 |
|  | Increased Urinary<br>Frequency |
|  | Impotence                      |

|  |                                   |
|--|-----------------------------------|
|  | Incontinence                      |
|  | Nighttime Urination<br>(Nocturia) |
|  | Pain with Urination<br>(Dysuria)  |
|  | Scrotal Swelling                  |
|  | Urinary Urgency                   |
|  | Urine Color Change                |
|  | Vaginal Bleeding /<br>Discharge   |
|  | Vaginal Spotting                  |

### Musculoskeletal

|  |                              |
|--|------------------------------|
|  | Arthritis                    |
|  | Bone Pain                    |
|  | Joint Pain                   |
|  | Muscle Weakness              |
|  | Decreased Range of<br>Motion |

### Neurologic

|  |                                      |
|--|--------------------------------------|
|  | Dizziness                            |
|  | Gait / Walking Difficulty            |
|  | Headaches                            |
|  | Difficulty Sleeping<br>(Insomnia)    |
|  | Memory Difficulties                  |
|  | Muscle Control<br>(Motor Neuropathy) |
|  | Paralysis                            |
|  | Seizure                              |
|  | Sensory Problems                     |
|  | Stroke                               |

### Endocrine

|  |                          |
|--|--------------------------|
|  | Diabetes                 |
|  | Hot Flashes              |
|  | Menstrual Irregularities |
|  | Thyroid Disease          |

### Hematologic/Lymphatic

|  |                     |
|--|---------------------|
|  | Easy Bruising       |
|  | Swollen Lymph Nodes |

### Allergies/Immunologic

|  |           |
|--|-----------|
|  | Allergies |
|  | Reactions |

### Skin (Integument)

|  |                      |
|--|----------------------|
|  | Hair Loss (Alopecia) |
|  | Bruising             |
|  | Itchiness (Pruritus) |
|  | Rash                 |
|  | Hives                |

### Breasts

|  |                       |
|--|-----------------------|
|  | Breast Masses / Lumps |
|  | Nipple Discharge      |
|  | Nipple Inversion      |
|  | Breast Pain           |

### Psychiatric

|  |                |
|--|----------------|
|  | Hallucinations |
|  | Depression     |
|  | Euphoria       |
|  | Mood Swings    |