Methodist Healthcare

(Place Patient Identification Sticker Here)

Surgical Oncology
7705 Poplar Ave, Building B, Suite 220
Germantown, Tennessee 38138
901-516-6792 • Fax: 901-266-6422

1265 Union Avenue, 2 Shorb
Memphis, Tennessee 38104
901-516-6792 • Fax: 901-266-6458

1377 S. Germantown Rd.
Germantown, Tennessee 38138
901-516-6792 • Fax: 901-266-6458

Surgical Oncology Patient Information

Date: _____/_____/_____-_____ (*mm/dd/year*)

Patient name: _____
Last *First* *Middle*

Patient address: _____
Street *City* *State* *Zip*

Patient phone numbers: Home: (_____) _____ Cell: (_____) _____

Work: (_____) _____ email: _____

Person completing this form: ❑ Patient ❑ Spouse ❑ Sibling ❑ Child ❑ Parent ❑ Friend

❑ Other (please specify) _____

Patient information: Date of Birth: _____/_____/_____ (*mm/dd/year*) Gender: ❑ Male ❑ Female

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Race/Ethnicity: ❑ White – (not Hispanic) ❑ Hispanic ❑ Black ❑ Asian/Pacific Islander ❑ Native American

❑ Other (please specify)_____

Emergency contact: Name: _____
Last *First* *Middle*

Relationship to Patient: _____

Address: _____
Street *City* *State* *Zip*

Contact phone numbers: Home: (_____) _____ Cell: (_____) _____

Work: (_____) _____ email: _____

Referring physician: _____

Medical oncologist: _____

Current medical history: What is the medical reason for referral to UTMP Surgical Oncology? (*Chief Complaint)*

_____

_____

_____

_____

_____

Date of diagnosis: _____/_____/_____ (*mm/dd/year*)

Food or drug allergies: _____

_____

_____

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Patient name_____ Date_____MRN_____

Past Medical History: (please check all that apply)

Heart and Blood Vessels
- ❑ None
- ❑ Heart failure
- ❑ High blood pressure
- ❑ Heart attack
- ❑ Poor circulation
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Irregular heart beat/arrhythmia
- ❑ Heart valve disease

Brain and Nerves
- ❑ None
- ❑ Headaches
- ❑ Neuropathy
- ❑ Parkinson's disease
- ❑ Dementia / Alzheimer's
- ❑ Seizures
- ❑ Meningitis
- ❑ Multiple sclerosis
- ❑ Chronic fatigue syndrome

Lungs
- ❑ None
- ❑ Emphysema
- ❑ Asthma
- ❑ Hay Fever
- ❑ COPD
- ❑ Tuberculosis
- ❑ Asbestosis
- ❑ Pulmonary embolus
- ❑ Sleep apnea

Stomach/Intestines
- ❑ None
- ❑ Gastric reflux
- ❑ Stomach ulcers
- ❑ Crohn's disease
- ❑ Ulcerative Colitis
- ❑ Diverticulitis / Diverticulosis
- ❑ Irritable bowel syndrome
- ❑ Gallstones
- ❑ Pancreatitis

Kidney / Bladder
- ❑ None
- ❑ Kidney Stones
- ❑ Kidney failure
- ❑ Dialysis
- ❑ Recurrent urinary infections

Blood Disorders
- ❑ None
- ❑ Anemia
- ❑ Sickle cell anemia
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Myelodysplastic disorder

Immune System
- ❑ None
- ❑ HIV/AIDS
- ❑ Frequent infections
- ❑ Lupus
- ❑ Rheumatoid arthritis

Joints / Skeleton
- ❑ None
- ❑ Osteoporosis
- ❑ Fractures
- ❑ Arthritis
- ❑ Gout
- ❑ Scoliosis

Liver
- ❑ None
- ❑ Hepatitis
  - ❑ Hepatitis A
  - ❑ Hepatitis B
  - ❑ Hepatitis C
  - ❑ Don't know
- ❑ Cirrhosis

Endocrine
- ❑ None
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Pituitary disease
- ❑ Adrenal disease

Psychological
- ❑ None
- ❑ Depression
- ❑ Anxiety
- ❑ Schizophrenia
- ❑ Addiction

Skin
- ❑ None
- ❑ Eczema
- ❑ Psoriasis
- ❑ Warts
- ❑ Shingles

Genetic Diseases
- ❑ None
- ❑ BRAC 1/2
- ❑ Cowden syndrome
- ❑ Familial adenomatous polyposis (FAP)
- ❑ Hereditary nonpolyposis colon cancer
- ❑ Multiple endocrine neoplasia - Type 1
- ❑ Multiple endocrine neoplasia - Type 2

Genitourinary Male
- ❑ None
- ❑ Prostate problems
- ❑ Testicular disorder
- ❑ Erectile dysfunction
- ❑ Urinary incontinence

Genitourinary Female
- ❑ None
- ❑ Vaginal problems
- ❑ Uterine bleeding
- ❑ Uterine fibroids
- ❑ Urinary incontinence
- ❑ Endometriosis
- ❑ Polycystic ovarian disease

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Current Medications:

Medication	Dose taken	Frequency (how many times/ day)	How long have you been on this medication?	Reason for taking?

Past Surgeries:

Type of surgery	Date/Year performed	Hospital/City performed	Surgeon

Prior Cancer History:

Prior cancer type	Age at diagnosis	Did you receive chemo-therapy? (yes/no)	Did you receive radiation treatment? (yes/no)	Did you have surgery (yes/no)	Did you have any other forms of treatment (yes/no)

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Family Medical History: (please list any significant medical problems that run in your family)

Family member	Medical diagnosis	Living (yes/no)
Father		
Mother		
Siblings		
Children		
Other		

Social History:

Occupation(s)	Length of time in current or previous position

History of tobacco use (yes/no)	Type (cigarettes, chewing tobacco, snuff)	Amount per day	Number of years used
History of alcohol use	**Type (beer, wine, whiskey)**	**Amount per day/wk/mo**	**Number of years used**
History of drug use	**Type (marijuana, cocaine, heroin, other)**	**Amount per day/wk/mo**	**Number of years used**

Current Performance Status: (please select one)

- ❑ 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.

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Review of Systems: please check any of the following that apply to symptoms you are recently or currently are experiencing. Please address each section and select "none" if there are no symptoms that apply to you.

General

- ❑ None
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Fatigue
- ❑ Weight gain
- ❑ Weight loss
- ❑ Pain
- ❑ Insomnia
- ❑ Other_____

Neurological

- ❑ None
- ❑ Memory changes
- ❑ Lightheadedness
- ❑ Dizziness
- ❑ Numbness/tingling
- ❑ Weakness
- ❑ Seizures
- ❑ Headache
- ❑ Ears ringing
- ❑ Hearing loss/difficulty
- ❑ Speech changes
- ❑ Tremors
- ❑ Visual changes
- ❑ Paralysis
- ❑ Other_____

Head & Neck

- ❑ None
- ❑ Nosebleeds
- ❑ Difficulty swallowing
- ❑ Painful swallowing
- ❑ Earaches
- ❑ Runny nose
- ❑ Hoarseness
- ❑ Change in voice
- ❑ Neck pain/stiffness
- ❑ Mass or lumps
- ❑ Other_____

Breast

- ❑ None
- ❑ Tenderness
- ❑ Swelling
- ❑ Pain
- ❑ Skin changes
- ❑ Mass or lumps
- ❑ Nipple discharge
- ❑ Other_____

Cardiovascular

- ❑ None
- ❑ Leg swelling
- ❑ Chest pain
- ❑ Blood pressure problems
- ❑ Shortness of breath
- ❑ Palpitations
- ❑ Other_____

Respiratory

- ❑ None
- ❑ Wheezing
- ❑ Excessive snoring
- ❑ Difficulty breathing
- ❑ Coughing
- ❑ Other_____

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Review of Systems: (continued) please check any of the following that apply to symptoms you are recently or currently are experiencing. Please address each section and select "none" if there are no symptoms that apply to you.

Gastrointestinal

- ❑ None
- ❑ Jaundice
- ❑ Nausea
- ❑ Constipation
- ❑ Black or bloody stool
- ❑ Change in appetite
- ❑ Reflux/heartburn
- ❑ Diarrhea
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Anal pain or itching
- ❑ Other_____

Genitourinary

- ❑ None
- ❑ Burning with urination
- ❑ Frequency
- ❑ Difficulty urinating
- ❑ Urinary incontinence
- ❑ Blood in urine
- ❑ Increased urination at night
- ❑ Pain with urinating
- ❑ Other_____

Musculoskeletal

- ❑ None
- ❑ Joint swelling
- ❑ Decreased flexibility
- ❑ Muscle weakness
- ❑ Muscle cramps
- ❑ Joint/back stiffness
- ❑ Other_____

Skin/Lymphatics

- ❑ None
- ❑ Rash
- ❑ Change in skin color
- ❑ Hair loss
- ❑ Excessive itching
- ❑ Changing mole
- ❑ Nail changes
- ❑ Lump in groin/armpit/neck
- ❑ Other_____

Endocrine

- ❑ None
- ❑ Cold intolerance
- ❑ Excessive thirst
- ❑ Heat intolerance
- ❑ Tremor
- ❑ Excessive urination
- ❑ Other_____

Hematologic

- ❑ None
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ History of blood clot
- ❑ Other_____

Psychological

- ❑ None
- ❑ Anxious/worried
- ❑ Depressed/sad
- ❑ Difficulty sleeping
- ❑ Other_____

Female Only

- ❑ None
- ❑ Vaginal/uterine bleeding
- ❑ Pain during intercourse
- ❑ Pelvic pain
- ❑ Menopause
  - ❑ yes ❑ no
- ❑ Other _____

Male Only

- ❑ None
- ❑ Erectile dysfunction
- ❑ Penile or testicular lump/mass
- ❑ Difficulty urinating
- ❑ Other _____

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For UTMP staff to complete:

Date _____/_____/_____

Height: _____ (cm) Weight _____ ((Kg)

Temp _____ (^{o}F) Pulse _____ (bpm)

Blood Pressure _____/_____ Resp _____

Pertinent Exam Findings:

Pertinent Laboratory:

Pertinent Imaging:

Clinical Impression/Diagnosis:

Plan:

_____ _____ _____

UTMP Staff Signature Date Time

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