Jefferson® University Physicians



# Initial Visit Questionnaire

Patient Name: ______ Date: ______

Address/City/State/Zip: ______

Sex: ____ Age: ____ Race: ______ Date of Birth: ______ Soc. Sec. #: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed Spouse/Signif. Other's Name: ______

Who else lives in your home? ☐ Spouse ☐ Significant Other ☐ Children (# ____ ) ☐ Other: ______

**Please complete if guarantor is other than self.** (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: ______ Date of Birth: ______

Patient's Relationship to Guarantor: ______ Sex: ____ Soc. Sec. #: ______

Address/City/State/Zip: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Employer: ______

Address/City/State/Zip: ______

## Emergency Contact Information

Contact Name: ______ Relationship to Patient: ______

Address/City/State/Zip: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

## Insurance Information

A separate form is required for workers' compensation, automobile liability, or legal services.

**PRIMARY CARRIER**: ______ Telephone #: ______

Address: ______

Group/Plan #: ______ ID/Cert #: ______

Subscriber's Name: ______ Subscriber's DOB: ______

Relationship to Patient: ______ Effective Date: ______

**SECONDARY CARRIER**: ______ Telephone #: ______

Address: ______

Group/Plan #: ______ ID/Cert #: ______

Subscriber's Name: ______ Subscriber's DOB: ______

Relationship to Patient: ______ Effective Date: ______

## Prescription Coverage Plan Information

Carrier: ______ Subscriber: ______

ID #: ______ Phone #: ______

Patient Name: ______________________ Date of Birth: __________

**Are your lab or x-ray studies capitated to a specific lab?** ☐ No ☐ Yes (If yes, specify below)

Blood work: ______________________ X-rays: ______________________

**To whom should letters be sent regarding your visit?**

Please provide full and accurate information for any physicians with whom we should communicate.

**Hematologist/Oncologist:**

Name: ______________________ Phone # __________

Address: ______________________

**Primary Care Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Other Relevant Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Other Relevant Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Other Relevant Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Other Relevant Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Other Relevant Physician:**

Name: ______________________ Phone # __________

Address: ______________________

**Retail Pharmacy:**

Name: ______________________ Phone # __________

Address: ______________________

**Mail Order Pharmacy:**

Name: ______________________ Phone # __________

Address: ______________________

***THIS PAGE FOR MEDICAL ONCOLOGY OFFICE USE ONLY***

Patient Name: ____________________ Date of Birth: ____________

What is the problem for which you are being referred to us? ____________________

When was this condition first diagnosed? ____________________

Please briefly summarize what you know of the treatments you have received for this condition. Include, surgery, radiotherapy, chemotherapy, and any other treatments with dates, drugs, schedules of treatment, type of surgery and any other information you may have.
*(We will separately contact your referring doctor, but his/her records are a complement to your description, not a substitute):*

| Date(s) | Treatment | Description |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any questions you would like to be sure are addressed during your initial visit with us:

Which of the following best describes your everyday activity level? (Check one)

- ☐ Normal activity. Fully active, able to carry on all activities without restriction. Able to climb at least one flight of steps without difficulty and walk at least 3 to 4 city blocks without difficulty.
- ☐ Some symptoms but able to get around. Restricted in physically strenuous activity but able to walk and carry out light work or activities which can be performed while sitting (e.g., light housework, office work)
- ☐ In bed less than half of the time. Able to walk sufficiently to perform all self-care, but unable to carry out any work activities. Up and about more than half of waking hours.
- ☐ In bed more than half of the time. Capable of only limited self-care, confined to bed or chair more than half of waking hours.
- ☐ Completely bedridden or disabled. Cannot carry on any self-care. Totally confined to bed or chair.

## Medications

Please list all of your current medications:

| Name | Doses | Frequency taken *(daily, twice a day, etc.)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name: ______________________ Date of Birth: ____________

Are you allergic to any medications? ☐ No ☐ Yes

If yes, please list the medicines to which you are allergic and the reaction you experienced:

| Medicine: | Allergic Reaction: |
|---|---|
| | |
| | |
| | |

Do you have any food allergies? ☐ No ☐ Yes

If yes, please list: ______________________

## Past Medical History *(Answer all questions. Check "Yes" or "No" as the question applies to you.)*

Do you have a history of any of the following medical problems?

| Condition | No | Yes | Condition | No | Yes | Condition | No | Yes |
|---|---|---|---|---|---|---|---|---|
| Anemia | ☐ No | ☐ Yes | Diabetes/High Blood Sugar | ☐ No | ☐ Yes | Emphysema/Chronic Bronchitis | ☐ No | ☐ Yes |
| Cancer/Leukemia/Lymphoma | ☐ No | ☐ Yes | Thyroid Disease | ☐ No | ☐ Yes | Ulcers | ☐ No | ☐ Yes |
| Easy Bleeding or Bruising | ☐ No | ☐ Yes | Stroke | ☐ No | ☐ Yes | Hepatitis | ☐ No | ☐ Yes |
| Colon Polyps | ☐ No | ☐ Yes | Seizures/Convulsions/Epilepsy | ☐ No | ☐ Yes | Cirrhosis | ☐ No | ☐ Yes |
| High Blood Pressure | ☐ No | ☐ Yes | Multiple Sclerosis | ☐ No | ☐ Yes | Kidney Disease | ☐ No | ☐ Yes |
| Heart Attacks/Angina | ☐ No | ☐ Yes | Tuberculosis | ☐ No | ☐ Yes | Venereal Disease | ☐ No | ☐ Yes |
| Rheumatic Fever | ☐ No | ☐ Yes | Pneumonia | ☐ No | ☐ Yes | Arthritis | ☐ No | ☐ Yes |
| Heart Murmur | ☐ No | ☐ Yes | Asthma | ☐ No | ☐ Yes | Systemic Lupus Erythematosus | ☐ No | ☐ Yes |
| Palpitations/Irregular Heart Beat | ☐ No | ☐ Yes | Hay Fever | ☐ No | ☐ Yes | Scleroderma | ☐ No | ☐ Yes |
| Congestive Heart Failure | ☐ No | ☐ Yes | Sinus Problems | ☐ No | ☐ Yes | HIV Infection | ☐ No | ☐ Yes |

Other: ______________________

Dates of last rectal exam/sigmoidoscopy/stool blood test: ______________________

In the event that your cancer treatment interferes with your fertility (ability to have children), would you like information about fertility preservation options?

☐ No ☐ Yes ☐ Not applicable (past child bearing age or previous surgical or health issue which precludes)

### Men Only

Prostate Enlargement . . . . . . ☐ No ☐ Yes Date of last PSA: ____________

Do you/your partner practice birth control? . . ☐ No ☐ Yes Methods used: ____________

### Women Only

Breast Lumps . . . . . . ☐ No ☐ Yes

Are you pregnant? . . . . . . ☐ No ☐ Yes If yes, how many months? ______

How many pregnancies have you had? ______ How many children have you delivered? ______

Do you/your partner practice birth control? . . ☐ No ☐ Yes Methods used: ____________

Age at which your menstrual periods started: ______

Are you still menstruating? . . . . . . ☐ No ☐ Yes If yes, date of last period: ____________

Have you reached menopause? . . . . . . ☐ No ☐ Yes If yes, did your periods ☐ stop naturally or ☐ as a result of treatment

Dates of last pelvic exam/pap smear/breast exam/mammogram: ______________________

Patient Name: ______________________ Date of Birth: ______________

Have you undergone surgery for any reason? ☐ No ☐ Yes

If yes, please list the surgical procedure and approximately when it was performed:

______________________ Date: ______________

______________________ Date: ______________

______________________ Date: ______________

______________________ Date: ______________

______________________ Date: ______________

## Family History

Do any family members-blood relative only *(Parents, Grandparents, Aunts, Uncles, First Cousins, Brothers, Sisters, or Children)* suffer from the following disease?

Anemia . . . . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Cancer/Leukemia/Lymphoma . . . . . . . . ☐ No ☐ Yes Who ______________

Easy Bleeding or Bruising . . . . . . . . . . . ☐ No ☐ Yes Who ______________

High Blood Pressure . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Heart Attacks/ Angina . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Congestive Heart Failure . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Diabetes/High Blood Sugar . . . . . . . . . . ☐ No ☐ Yes Who ______________

Thyroid Disease . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Stroke . . . . . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Multiple Sclerosis . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Tuberculosis . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Emphysema/Chronic Bronchitis . . . . . . ☐ No ☐ Yes Who ______________

Hepatitis/Cirrhosis . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Colon Polyps . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Kidney Disease . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Systemic Lupus Erythematosus . . . . . . ☐ No ☐ Yes Who ______________

Scleroderma . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Who ______________

Other: ______________

**Is your father alive?** . . . . . . . . ☐ No ☐ Yes If yes, current age ______

- If no, age and cause of death: ______________
- Comments about his health: ______________

**Is your mother alive?** . . . . . . . ☐ No ☐ Yes If yes, current age ______

- If no, age and cause of death: ______________
- Comments about her health: ______________

**How many brothers/sisters do you have?** # of Brothers: ______ # of Sisters: ______

- Ages of brothers: ______________ Ages of sisters: ______________
- Comments about their health: ______________

______________

**How many children do you have?** # of Sons: ______ # of Daughters: ______

- Ages of sons: ______________ Ages of daughters: ______________
- Comments about their health: ______________

______________

Patient Name: ______________________ Date of Birth: ____________

## Social History:

Occupation: ______________________ Number of years in this job: ______

| Former jobs: | Number of years: | Former jobs: | Number of years: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Have you ever been a cigarette smoker?** . . . . . . . . . ☐ No ☐ Yes Packs per day: ______

- Number of years you have smoked: ______
- Are you still smoking: . . . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Year you quit: ______

**Have you ever smoked a cigar or pipe?** . . . . . . . . . . ☐ No ☐ Yes

- Describe: ______________________

**Do you drink alcohol?** . . . . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes

- Amount/Frequency: ______________________

**Do you use “recreational” drugs (circle the relevant drugs):** . . . . ☐ No ☐ Yes

- Marijuana, Cocaine, Amphetamines, Barbituates, Heroin or other Narcotics, Hallucinogens, other ______
- Have you used any of these drugs in the past? . . . ☐ No ☐ Yes
- Describe: ______________________

## Decision Making:

- Do you have an advanced directive or living will? (a document that explains your wishes, if you are too ill to make medical decisions for yourself) ☐ No ☐ Yes If “Yes,” please give a copy to our office staff.
- Do you have a durable power of attorney? (a person authorized to act on your behalf, if you are too ill to make medical decisions for yourself) ☐ No ☐ Yes If “Yes,” please print the person’s name below.

(Print durable power of attorney name) ______________________

**Patient’s Signature:** ______________________ **Date:** ____________

## Physician comments about medical history:

______________________

**Physician’s Signature:** ______________________ **Date:** ____________ **Time:** ____________

Patient Name: ________________________________ Date of Birth: ______________

## Review of Systems

Have you recently experienced any of the following problems? If so please describe.

**General/Constitutional:**

- Fever, Chills, or Sweats . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Change in Appetite/Weight Loss . . ☐ No ☐ Yes Describe ____________
- Fatigue . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- New Pain . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Changes in Pain Medication . . . . . ☐ No ☐ Yes Describe ____________

**Skin & Breast:**

- Rash. . . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Itching . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Blisters . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Pain/Redness of Port/Catheter . . . ☐ No ☐ Yes Describe ____________
- Breast Lump/Nipple Discharge . . . ☐ No ☐ Yes Describe ____________

**Hematologic/Oncologic:**

- Swollen Glands/Lumps . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Bruising/Bleeding . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Paler than usual . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________

**Neurologic:**

- Headache . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Numbness/Tingling . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Speech or Memory Change . . . . . ☐ No ☐ Yes Describe ____________
- Problems with Balance/Dizziness . ☐ No ☐ Yes Describe ____________
- Weakness . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________

**Ophthalmologic:**

- Change in Vision . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Dryness/Pain/Tearing of eyes . . . . ☐ No ☐ Yes Describe ____________

**Head/Ears/Nose/Throat:**

- Hair Loss . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Hearing Problems . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Sinus Pain/Congestion . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Dry Mouth/Sores . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Sore Throat/Hoarseness . . . . . . . . ☐ No ☐ Yes Describe ____________
- Trouble Swallowing . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Stiff Neck . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________

**Cardiovascular:**

- Chest Pain . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________
- Palpitations/Irregular Heart Beat . . ☐ No ☐ Yes Describe ____________
- Swelling . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ____________

Patient Name: ______________________ Date of Birth: ______________

**Respiratory:**

Shortness of Breath . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Painful Breathing . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Cough/Sputum Production . . . . . . ☐ No ☐ Yes Describe ______________

Wheezing . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

**Gastrointestinal:**

Stomach/Abdominal Pain . . . . . . . ☐ No ☐ Yes Describe ______________

Nausea/Vomiting . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Loose Stool/Diarrhea . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Constipation . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Blood in Stool . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Black Stools . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Describe appetite: ______________

**Genitourinary:**

Pain on Urinating . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Blood in Urine . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Trouble Initiating Urine Stream . . . ☐ No ☐ Yes Describe ______________

Awakening to Urinate . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Sexual Problems . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Vaginal Bleeding/Spotting . . . . . . . ☐ No ☐ Yes Describe ______________

**Musculoskeletal:**

Muscle Ache/Pain . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Joint Pain/Swelling/Stiffness . . . . . ☐ No ☐ Yes Describe ______________

Bone Pain . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Falls within the last year . . . . . . . . ☐ No ☐ Yes How many? ______

**Emotional:**

Anxiety . . . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Depression . . . . . . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

Trouble Sleeping . . . . . . . . . . . . . . ☐ No ☐ Yes Describe ______________

**Other:** ______________

Describe other problems conditions you would like to make known to your doctor:

______________

______________

______________

______________

**Patient's Signature:** ______________ **Date:** ______________

**Physician's Statement:**

**Physician's Signature:** ______________ **Date:** ______________ **Time:** ______________