



# NEW PATIENT INFORMATION

A DIVISION OF  
**MINNESOTA ONCOLOGY**

FULL NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_ OTHER \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_

SEX AT BIRTH:  FEMALE  MALE

GENDER IDENTITY:  CHOOSE NOT TO DISCLOSE  FEMALE  MALE  
 TRANSGENDER MALE  GENDER QUEER (NEITHER EXCLUSIVELY MALE OR FEMALE)  
 TRANSGENDER FEMALE  OTHER

PRONOUNS:  HE/HIM/HIS  SHE/HER/HERS  THEY/THEM /THIER  
 CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION:  CHOOSE NOT TO DISCLOSE  BISEXUAL  LESBIAN/GAY/HOMOSEXUAL  
 STRAIGHT/HETEROSEXUAL  DON'T KNOW  OTHER

NAME OF SIGNIFICANT OTHER \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ MAIL ORDER \_\_\_\_\_

WHY ARE YOU HERE TODAY? \_\_\_\_\_

ANY TESTING ALREADY DONE FOR YOUR PROBLEM/DIAGNOSIS?  YES  NO

IF YES EXPLAIN: \_\_\_\_\_

## PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ABNORMAL PAP               | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> REFLEX/GERD                           |
| <input type="checkbox"/> CERVICAL/ANAL ANEMIA       | <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> SEIZURES/EPILEPSY                     |
| <input type="checkbox"/> ASTHMA/COPD                | <input type="checkbox"/> HIGH CHOLESTEROL       | <input type="checkbox"/> SKIN DISEASE/RASHES                   |
| <input type="checkbox"/> ABNORMAL PAP               | <input type="checkbox"/> HEPATITIS              | <input type="checkbox"/> STD/PID                               |
| <input type="checkbox"/> CANCER                     | <input type="checkbox"/> INCONTINENCE           | <input type="checkbox"/> STROKE                                |
| WHERE: _____  | <input type="checkbox"/> IRREGULAR HEARTBEAT    | <input type="checkbox"/> THROID PROBLEMS                       |
| <input type="checkbox"/> COLITIS/DIVERTICUOSIS      | <input type="checkbox"/> LIVER DISEASE          | <input type="checkbox"/> UCLERS/GASTRITIS                      |
| <input type="checkbox"/> COLON POLYPS               | <input type="checkbox"/> LUNG DISEASE           | <input type="checkbox"/> URINARY PROBLEMS/ PELVIC<br>PROLASPSE |
| <input type="checkbox"/> CROHN'S/ULCERATIVE COLITIS | <input type="checkbox"/> KIDNEY DISEASE/STONES  |  |
| <input type="checkbox"/> DEPRESSION/ANXIETY         | <input type="checkbox"/> PHLEBITIS/BLOOD CLOTS  |  |
| <input type="checkbox"/> DIABETES                   | <input type="checkbox"/> POSTOPREATIVE BLEEDING |  |

COMMENTS/OTHERS: \_\_\_\_\_

PREVIOUS CANCER TREATMENTS?  YES  NO

IMMUNIZATIONS CURRENT  YES  NO

LAST FLU SHOT \_\_\_\_\_ PNEUMONIA SHOT \_\_\_\_\_ COVID VACCINE \_\_\_\_\_

PROSTHETIC DEVICES/IMPLANTS?  YES  NO TYPE: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PREVIOUS OPERATIONS:

\_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_ YEAR \_\_\_\_\_

LAST COLONOSCOPY DATE: \_\_\_\_\_ HISTORY OF POLYPS:  YES  NO

**FEMALES**

NUMBER OF PREGNANCIES \_\_\_\_\_ # VAGINAL DELIVERIES \_\_\_\_\_  
 TEAR OR EPISOTOMY WITH DELIVERY?  YES  NO  
 C-SECTIONS \_\_\_\_\_ INCONTINENCE POST-PARTUM?  YES  NO  
 ABNORMAL CERVICAL PAP  YES  NO PREVIOUS HPV INFECTION  YES  NO  
 CERVICAL LEEP / CONE  YES  NO

**MALES**

LAST PSA TEST \_\_\_\_\_ PREVIOUS TREATMENT FOR PROSTATE CANCER?  NO  SURGERY  RADIATION

**SOCIAL HISTORY**

MARITAL STATUS: (OPTIONAL)  SINGLE  MARRIED  WIDOWED  DIVORCED  OTHER  
 OCCUPATION  RETIRED  UNEMPLOYED  
 DO YOU SMOKE OR USE TOBACCO?  YES  NO  
 HOW MANY PACKS PER DAY? \_\_\_\_\_ FOR HOW MANY YEARS? \_\_\_\_\_  
 PREVIOUS TOBACCO?  YES  NO CHEW/DIP  YES (amount) \_\_\_\_\_  NO VAPE  YES (amount) \_\_\_\_\_  NO  
 DO YOU DRINK ALCOHOL?  YES (amount) \_\_\_\_\_  NO

**MEDICATIONS**

DO YOU TAKE ASPIRIN  YES  NO BLOOD THINNERS  YES  NO  
 STEROIDS?  YES  NO (most recent dose) \_\_\_\_\_

**LIST ALL MEDICATIONS YOU TAKE (INCLUDING OVER THE COUNTER MEDICINES AND VITAMINS, HERBS, AND SUPPLEMENTS)**

NAME	DOSE	HOW OFTEN

**FAMILY HISTORY**

ANY FAMILY MEMBERS WITH THE FOLLOWING CONDITIONS? (list family members if yes)  
 HIGH BLOOD PRESSURE  YES  NO HIGH CHOLESTEROL  YES  NO  
 DIABETES  YES  NO CROHNS OR COLITIS  YES  NO  
 COLON, RECTAL OR ANAL CANCER  YES  NO  
 OTHER CANCER  YES  NO (If YES, type and family member) \_\_\_\_\_

**ALLERGIES (Please check box and state reaction):**

CT SCAN DYE \_\_\_\_\_  LATEX \_\_\_\_\_  IODINE \_\_\_\_\_

FOODS/ENVIRONMENTAL \_\_\_\_\_

MEDICINES (Specify medicine & reaction)

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

NO KNOWN ALLERGIES (Please check if you have no known allergies)