



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 | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SEIZURES/EPILEPSY |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> SKIN DISEASE/RASHES |
| <input type="checkbox"/> ASTHMA/COPD | <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"/> THYROID PROBLEMS |
| <input type="checkbox"/> COLITIS/DIVERTICULOSIS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> ULCERS/GASTRITIS |
| <input type="checkbox"/> COLON POLYPS | <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> URINARY PROBLEMS/ PELVIC
PROLAPSE |
| <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)