



# TORRANCE MEMORIAL

## HUNT CANCER INSTITUTE

### Initial Patient Intake Form

#### Patient Registration

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
(last) (first) (middle)

Address \_\_\_\_\_  
(city) (state) (zip)

Date of birth \_\_\_\_\_ (mm/dd/yyyy) SSN # \_\_\_\_\_

Current Gender Identity:  Male  Female  Transgender

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_  
(city) (state) (zip)

Spouse's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Primary Care Provider (PCP) \_\_\_\_\_ Tel \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

Referring physician (if not PCP) \_\_\_\_\_ Tel \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

#### Emergency Contact Information

Name of friend/or nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to you: \_\_\_\_\_

#### Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
(last) (first) (middle)

Address \_\_\_\_\_ Contact phone \_\_\_\_\_

Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_



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**Social History:**

Married \_\_\_ Single \_\_\_ Divorced \_\_\_ (Year \_\_\_) Widowed \_\_\_ (Year \_\_\_)

Present marriage/number of years \_\_\_\_\_ Previous marriage/number of years \_\_\_\_\_

*\*If not previously indicated please complete*

\*Present occupation \_\_\_\_\_ \*Previous Occupations \_\_\_\_\_

\*Education \_\_\_\_\_ \*Spouse's Occupation \_\_\_\_\_

Persons currently living in your home \_\_\_\_\_

Do you have a living will/Advanced Directive/Polst? No \_\_\_ Yes \_\_\_ (please provide a copy)

**Language Spoken:**

Primary Language: \_\_\_\_\_ Preferred Language of Communication (if different): \_\_\_\_\_

Needs Interpreter: Yes \_\_\_ No \_\_\_ (comfortable communicating with English)

**Religion/Culture:**

What is your religious affiliation (optional)? \_\_\_\_\_

Are there religious/cultural beliefs that will/could impact your treatment? No \_\_\_ Yes \_\_\_

Please explain: \_\_\_\_\_

**Self-Reporting History & Physical:**

Reason for this visit (chief complaint) : \_\_\_\_\_

Onset of illness: \_\_\_\_\_ Date: \_\_\_\_\_ Symptom: \_\_\_\_\_

Do you have any know genetic/predisposition to disease? No \_\_\_ Yes \_\_\_, explain: \_\_\_\_\_

**Medical History:**

Illness/injury	Date



# TORRANCE MEMORIAL HUNT CANCER INSTITUTE

Surgeries/hospitalizations

Date

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\*If more space needed please attach list to this page

Implants: No \_\_\_ Yes \_\_\_, explain \_\_\_\_\_

**Have you ever received Hormone Therapy or Chemotherapy?** No \_\_\_\_\_ Yes \_\_\_\_\_

Medical Oncologist: Name \_\_\_\_\_

Address \_\_\_\_\_

Medication: \_\_\_\_\_ Date Received: \_\_\_\_\_

Medication: \_\_\_\_\_ Date Received: \_\_\_\_\_

**Have your ever received Radiation Therapy?** No \_\_\_\_\_ Yes \_\_\_\_\_

Radiation Oncologist: Name \_\_\_\_\_

Address \_\_\_\_\_

What area received radiation therapy? \_\_\_\_\_

**Female:**

Are you now, or is there a possibility that you might be pregnant? No \_\_\_ Yes \_\_\_ **Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Deliveries: \_\_\_\_\_ Did you Breastfeed? \_\_\_\_\_

Have you ever taken Hormones?( Estrogens, Birth Control pills, Androgens, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type and for how long? \_\_\_\_\_

Do you still have menstrual periods? No \_\_\_\_\_ Yes \_\_\_\_\_ Date of last period \_\_\_\_\_

**Habits:**

Smoking? Yes / No How many packs each day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Alcohol? Yes / No What type? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Have you ever used 'street' (illegal) intravenous drugs? No/Yes

Have you ever been tested for the HIV/AIDS virus? No/ Yes. If yes, what was the result? \_\_\_\_\_

Have you ever been tested for Hepatitis? No/ Yes. If yes, what was the result? \_\_\_\_\_





**Review of Systems:**

**General** **YES**  
 Weight loss .....   
 Loss of appetite .....   
 Dry mouth/dehydration .....   
 Fatigue .....   
 Chills .....

**Skin:**  
 Redness/rash.....   
 Swelling .....   
 Moles .....   
 Bruising .....   
 Hair Loss .....   
 Nail changes .....

**Eyes**  
 Vision changes.....   
 Cataracts .....   
 Redness .....   
 Swelling .....   
 Pain .....

**Ears**  
 Discharge .....   
 Hearing Loss .....

**Nose**  
 Discharge .....   
 Bleeding .....

**Throat**  
 Swelling .....   
 Pain .....   
 Mouth sores .....

**Immunologic**  
 Swollen glands .....   
 Infections .....   
 Fevers .....   
 Autoimmune disease(lupus, rheumatoid arthritis)

**Breast**  
 Lumps .....   
 Discharge.....   
 Bleeding.....   
 Pain .....

**Lungs**  
 Cough .....   
 Blood in sputum .....   
 Shortness of breath .....   
 Asthma .....   
 Tuberculosis .....

**Heart** **YES**  
 Chest pain .....   
 Heart palpitation .....   
 High blood pressure .....

**Gastrointestinal**  
 Nausea .....   
 Vomiting .....   
 Diarrhea .....   
 Constipation .....   
 Abdominal/stomach pain .....   
 Black/bloody stool .....

**Urinary**  
 Kidney problems .....   
 Bladder problems .....   
 Blood in urine .....   
 Burning urination .....   
 Frequent urination .....

**Genital**  
 Prostate problems .....   
 Scrotal pain .....   
 Scrotal mass .....   
 Ovary problems .....   
 Uterus problems .....   
 Vaginal discharge .....   
 Vaginal Pain .....

**Hormonal**  
 Diabetes .....   
 Thyroid problems .....   
 High cholesterol .....

**Blood**  
 Anemia .....   
 Low blood counts .....   
 Blood clots .....

**Neurologic**  
 Numbness .....   
 Tingling .....   
 Dizziness/fainting spells Headaches .....   
 Seizures .....   
 Multiple sclerosis .....

**Psychiatric**  
 Depression .....   
 Anxiety .....   
 Schizophrenia .....   
 Mania .....



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### Family History:

Relation	Age	State of Health	Cancer Diagnosis	Deceased, cause of Death	Age of Death	Known Genetic Abnormality
Father						
Mother						
Siblings						
Children						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Other Relatives						

**PLEASE LIST ALL OF YOUR PRESENT PHYSICIAN:**

	Referring Physician <input type="checkbox"/> Seen for current problem	Other Physician <input type="checkbox"/> Seen for current problem	Other Physician <input type="checkbox"/> Seen for current problem
Name			
Address			
Telephone			
	<input type="checkbox"/> Please send reports to this physician <input type="checkbox"/> Do Not send reports	<input type="checkbox"/> Please send reports to this physician <input type="checkbox"/> Do Not send reports	<input type="checkbox"/> Please send reports to this physician <input type="checkbox"/> Do Not send reports

**Should We Contact Someone to Obtain Your Records?**

	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility
Name			
Address			
Telephone			
Study (CT, MRI, Biopsy, etc)			

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If completed by someone other than patient:**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_