St.JosephHealth
Medical Group

Patient Information Packet

Dear ____

Please use ink to fill out these forms, in full, prior to your appointment with:

Dr. ___________________________ on ____ / ____ / ____ at ___________ ☐ AM ☐ PM

Your appointment is at the following location:

☐	1100 Trancas Street #256, Napa Phone: (707) 253-7161 (Medical Oncology)	☐	3555 Round Barn Circle, Santa Rosa Phone: (707) 528-1050 (Medical & Radiation Oncology)
☐	5150 Hill Road East, #F, Lakeport Phone: (707) 262-3060 (Medical Oncology)	☐	110 Lynch Creek Way, #A, Petaluma Phone: (707) 763-0600 (Medical & Radiation Oncology)
☐	1165 South Dora Street, #H, Ukiah Phone: (707) 463-3636 (Radiation Oncology)	☐	

Instructions for your first appointment (if checked):

- ☐ **Bring this packet with you, with all forms completed** (note that most pages are two-sided).
- ☐ **Bring your current insurance card.**
- ☐ **Bring pertinent films** (such as X-Ray, CT or MRI) with you to your appointment. Request the films from the facility where they were performed.
- ☐ **Bring a list of all medications** you are currently taking, including dosage and frequency.
- ☐ **Bring all prescription bottles and over the counter medications** that you are currently taking
- ☐ **Arrive_____ minutes early to register.** Failure to do so may result in a delay of your appointment.

Thank you for your cooperation. We look forward to meeting you and assisting you in any way we can.

Sincerely ______________________________

St. Joseph Health

If you have questions, please call: ___________________________

For more information about your group: https://www.psjhmedgroups.org/Northern-California.aspx

PLEASE COMPLETE BOTH SIDES OF THIS FORM

St.JosephHealth Medical Group

Patient Medical History

Date: ________________

Name____
First Middle Last

Sex ☐ Male ☐ Female Age _________ Date of Birth: _______________________

What have you been told thus far about the nature of your condition and the reason for your referral to our office?

____

____

Please summarize chronologically the history of your condition and symptoms, including any tests that have been done so far (with approximate dates).

____

____

____

____

____

What symptoms are you currently having that you think may be related to your condition?

____

____

____

____

____

Please list any questions you have regarding your condition that you want to be sure we discuss during your visit·

____

____

____

____

____

Would you be interested in discussing participation in a research study if one is available for your condition? ☐ Yes ☐ No

Some cancers may be inherited (hereditary). If you are seeing the Oncologist for cancer and there is the possibility it is hereditary, would you be interested in a genetic counseling appointment? ☐ Yes ☐ No

Surgeries (including biopsies)

Type ______________________________ Year _______ Location __________________

Type ______________________________ Year _______ Location __________________

Type ______________________________ Year _______ Location __________________

Hospitalizations for non-surgical conditions
(For example: serious infections, asthma attack, car accident with injuries, etc.)

Condition _________________________ Year _______ Location __________________

Condition _________________________ Year _______ Location __________________

Condition _________________________ Year _______ Location __________________

Chronic medical conditions for which you see your doctor periodically
(For example: high blood pressure, diabetes, high cholesterol)

Conditions: ____

____

____

____

Current medications (including vitamins, herbs, and supplements)

Name	Dose	Frequency	Reason	Start Date

Allergies or intolerances to medications

Medication	Reaction	Severity

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Substance Use/Exposure

Tobacco: Do you now or have you ever smoked? ☐ Yes ☐ No

If yes: How many years have you smoked (or did you smoke) cigarettes? __________

How many packs of cigarettes per day do you currently smoke? __________

If no longer smoking, when did you stop? __________

Average number of packs per day smoked over your lifetime __________

Have you smoked a pipe or chewed tobacco? __________

Would you like to receive "stop smoking" information? __________

Alcohol: How many drinks do you have in an average day? __________

How many drinks do you have in an average week? __________

Other drugs: Type and amount: ____

Have you had exposure to occupational chemicals or toxins? ☐ Yes ☐ No

If yes, please list: ____

Personal History

Other states or countries in which you have lived

____

____

Employment History

Current Employer: ______________________ Work Phone: (_____) ______________________

Current Occupation: ____

Past Occupation: ____

Past Occupation: ____

Educational History

Highest level of education attained: ____

Family Information

Marital Status: ______________________ If married, how long? ______________

Name of spouse: ____

Family History

Father, Mother, Brothers & Sisters	Age attained	Cause of death, if deceased	Other medical problems during life (especially cancer)

Continues on next page…

Family History (continued)

Children, others	Age attained	Cause of death, if deceased	Other medical problems during life (especially cancer)

Symptoms / History by organ system

General:	Yes	No	Comments
Is your appetite normal?	☐	☐	
Have you lost weight? How much over how many months?	☐	☐	
Have you had any unexplained fevers or sweats?	☐	☐	
Difficulty with sense of smell?	☐	☐	
Hearing loss?	☐	☐	
Wear a hearing aid?	☐	☐	
Vision problems?	☐	☐	
Dizziness?	☐	☐	
Problems with pain? Where?	☐	☐	

Lungs:	Yes	No	Comments
Do you have a history of asthma, COPD, chronic bronchitis, emphysema?	☐	☐	
Do you have a chronic cough or blood in sputum?	☐	☐	
Do you get short of breath easily?	☐	☐	
Have you had a positive PPD skin test or exposure to tuberculosis?	☐	☐	

Heart and Circulation:	Yes	No	Comments
Have you had a heart attack or angina (chest pain)?	☐	☐	
Have you had congestive heart failure?	☐	☐	
Have you had an irregular heart rhythm?	☐	☐	
Do you have a heart murmur or known valvular heart disease?	☐	☐	
Do you have hypertension (high blood pressure)?	☐	☐	
Do you have pain in your calf muscles when walking? After how far?	☐	☐	
Have you had blood clots in your legs or lungs?	☐	☐	

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Abdomen:	Yes	No	Comments
Do you have chronic heartburn or indigestion?	☐	☐	
Do you have difficulty or pain with swallowing?	☐	☐	
Have you had esophagitis, gastritis or an ulcer?	☐	☐	
Do you experience abdominal fullness or pressure?	☐	☐	
Have you had hepatitis, cirrhosis or liver disease?	☐	☐	
Have you had gallstones or gallbladder disease?	☐	☐	
Have you had pancreatitis?	☐	☐	
Do you have chronic diarrhea or constipation?	☐	☐	
Have you had rectal pain or bleeding?	☐	☐	

Urinary Tract:	Yes	No	Comments
Do you have a history of kidney stones or other kidney problems?	☐	☐	
Do you have a history of bladder problems or blood in the urine?	☐	☐	
Urination at night? If so, how often?	☐	☐	
For men: Do you have a history of prostate problems or trouble with urination?	☐	☐	
For men: Do you have lumps in your testicles?	☐	☐	

Gynecologic/Obstetric (for women):	***N/A***	Response
How many times have you been pregnant?	☐	
How many live births have you had?	☐	
Age at first pregnancy:	☐	
Age at first menstrual period?	☐	
Date of last menstrual period?	☐	
Vaginal bleeding after menopause?	☐	
Is your menstrual cycle regular?	☐	
How many total years of Hormone Replacement Therapy?	☐	
How many total years of oral contraceptive use?	☐	
When was your last pelvic/pap?	☐	
When was your last mammogram?	☐	

Skin:	Yes	No	Comments
Skin cancer? What kind?	☐	☐	
Eczema or psoriasis?	☐	☐	
Other chronic skin condition?	☐	☐	

Neurologic / Psychiatric:	Yes	No	Comments
Do you have frequent and/or severe headaches?	☐	☐	
Do you have a history of seizures or stroke?	☐	☐	
Do you experience numbness of fingers or toes?	☐	☐	
Do you have any unexplained neurologic symptoms?	☐	☐	
Do you have a history of depression or other psychological problems?	☐	☐	

Musculoskeletal:	Yes	No	Comments
Do you have arthritis? Which joints?	☐	☐	
Do you have a personal or family history of osteoporosis (thinning of bones)?	☐	☐	
Have you ever had a bone density test?	☐	☐	
Have you ever had a broken bone or a collapsed vertebra?	☐	☐	
Do you have joint pain or swelling?	☐	☐	
Back pain?	☐	☐	

Endocrine/Hormonal:	Yes	No	Comments
Diabetes? Age at onset?	☐	☐	
Thyroid problems?	☐	☐	
Disorders of pituitary or adrenal glands?	☐	☐	

Allergic/Immunologic:	Yes	No	Comments
Do you have seasonal allergies?	☐	☐	
Do you usually get a yearly flu vaccination?	☐	☐	
Have you ever had the pneumonia vaccine (Pneumovax)? When?	☐	☐	
Have you ever been tested for HIV? Results?	☐	☐	
Have you had any unusual or severe infections?	☐	☐	

Blood/Cancer:	Yes	No	Comments
Have you ever been anemic?	☐	☐	
Have you ever had a blood transfusion?	☐	☐	
Do you have a blood disorder?	☐	☐	
Have you had persistent swelling of glands?	☐	☐	
Have you ever had cancer?	☐	☐	
Have you ever received chemotherapy or radiation therapy?	☐	☐	

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Basic Imaging Screening Information	Yes	No	Comments
Are you allergic to iodine or shellfish?	☐	☐	
If yes, what happens?			
Are you diabetic?	☐	☐	
If yes, do you take Glucophage (metformin)?	☐	☐	
Do you have a history of asthma?	☐	☐	
Are you pregnant?	☐	☐	
Do you have a cardiac pacemaker?	☐	☐	
Do you have an implanted port (catheter)	☐	☐	
Have you ever had metal in your body?	☐	☐	
Have you ever worked with welding or grinding without eye protection?	☐	☐	
Are you claustrophobic (afraid of enclosed spaces)?	☐	☐	

Current Pharmacy

Name of Pharmacy ____

Phone Number (____) __________________ City: ______________________________________

If you use a mail order pharmacy, please provide you ID number:

ID Number: ____

St. Joseph Health Medical Group

Review of Systems (ten or more systems reviewed)

NO	YES	
Constitutional:		
☐	☐	Lack of appetite
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Night sweats
☐	☐	Weight change
Eyes:		
☐	☐	Blurred vision
☐	☐	Double vision
ENMT:		
☐	☐	Dysphagia (difficulty swallowing)
☐	☐	Ear Pain
☐	☐	Decreased hearing
☐	☐	Mouth dryness
☐	☐	Sputum production
☐	☐	Stomatitis (mouth sores)
☐	☐	Altered taste
Neck:		
☐	☐	Masses
Integumentary:		
☐	☐	Alopecia (loss of hair)
☐	☐	Blisters
☐	☐	Bruising
☐	☐	Pruritus (itchy skin)
☐	☐	Rash
Breasts:		
☐	☐	Breast masses
☐	☐	Nipple discharge
☐	☐	Nipple inversion
☐	☐	Breast pain
Cardiovascular:		
☐	☐	Chest pain
☐	☐	Dyspnea (shortness of breath)
☐	☐	Palpitations (irregular beats)

• Cont. Review of Systems

NO	YES	
Respiratory:		
☐	☐	Cough
☐	☐	Dyspnea (shortness of breath)
☐	☐	Hemoptysis (coughing up blood)
☐	☐	Wheezing
Gastrointestinal:		
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Hematochezia (bloody stools)
☐	☐	Nausea
☐	☐	Vomiting
Endocrine:		
☐	☐	Hot flashes
☐	☐	Menstrual irregularities
GU:		
☐	☐	Dysuria {pain on urination)
☐	☐	Urinary frequency
☐	☐	Hematuria (blood in urine)
☐	☐	Incontinence
☐	☐	Nocturia (get up to urinate at night)
☐	☐	Problems with sexual function
☐	☐	Vaginal discharge/bleeding
Musculoskeletal:		
☐	☐	Arthritis
☐	☐	Bone pain
☐	☐	Joint pain
☐	☐	Muscle weakness
☐	☐	Decreased range of motion
Neurologic:		
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Insomnia (poor sleep)
☐	☐	Memory loss
☐	☐	Seizure
Psychiatric:		
☐	☐	Depression
Hematologic:		
☐	☐	Lymph nodes

Most recent Mammo: ____/____/____

Most recent Pap: ____/____/____