



**NEW PATIENT INFORMATION**

USE PATIENT LABEL

Your Contact Info

Emergency Contact #1

Emergency Contact #2

**Name:** \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_

**What is your mailing address?** \_\_\_\_\_

**Who do you live with?**     I Live Alone     With Spouse/Significant Other     With My Children     Other

**Language(s) you speak:** \_\_\_\_\_

**Your occupation:** \_\_\_\_\_    **Your health insurance:** \_\_\_\_\_

**What is the best way(s) to contact you?**     Phone Call     Text Message     Email     Letter

**Who should be contacted to schedule tests and procedures?**     Patient     Another Person: \_\_\_\_\_

**Primary Care Physician: Name:** \_\_\_\_\_    **Telephone #:** \_\_\_\_\_

**Office Location:** \_\_\_\_\_

**Doctors You Have Seen for Cancer:** \_\_\_\_\_

**Have you ever had prior radiation therapy?**     Yes     No

If yes, when and at what facility? \_\_\_\_\_

**Have you ever had prior chemotherapy?**     Yes     No

If yes, when and at what facility? \_\_\_\_\_

**Do you have an Implanted Device (such as a Pacemaker, Defibrillator, or Neurostimulator)?**     Yes     No

If yes, what type of device, make and model number: \_\_\_\_\_

**Are you pregnant?**     Yes     No     Not Applicable

**Do you have an Advance Directive?**     Yes     No

Would you like information regarding an Advance Directive?     Yes     No

**Do you currently smoke cigarettes?**     Yes     No

If yes, are you interested in seeing a specialist to help you quit smoking?     Yes     No

**Have you ever undergone any of the following screening tests for cancer?**

Colonoscopy for colon cancer?     Yes     No       CT scan of chest for lung cancer?     Yes     No

PSA blood test for prostate cancer?     Yes     No

Mammogram for breast cancer?     Yes     No       Pap smear for cervical cancer?     Yes     No

**CONTINUE ON BACK**

**UNIVERSITY HOSPITAL • RUTGERS CINJ  
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| <b>System Review: Please check "yes" or "no" box to indicate if you currently have any of the following:</b> |            |           |                                   |            |           |
|--|------------|-----------|-----------------------------------|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |                                   | <b>Yes</b> | <b>No</b> |
| <b>Eyes</b>  |            |           | <b>Gastrointestinal</b>           |            |           |
| Eye Discharge  |            |           | Abdominal pain                    |            |           |
| Eye Pain   |            |           | Stool change (tar-like or bloody) |            |           |
| <b>Head/Ears/Nose/Throat</b>   |            |           | <b>Genitourinary</b>              |            |           |
| Headache   |            |           | Constipation                      |            |           |
| Dizziness  |            |           | Diarrhea                          |            |           |
| Hearing loss   |            |           | Nausea/Vomiting                   |            |           |
| Pain in ears   |            |           | <b>Reproductive</b>               |            |           |
| Ringing in ears  |            |           | Difficulty urinating              |            |           |
| Nose bleeds  |            |           | Burning on urination              |            |           |
| Congestion   |            |           | Frequent urination                |            |           |
| Dental Problems  |            |           | Nighttime urination               |            |           |
| Sore Throat  |            |           | Trouble with stream               |            |           |
| Difficulty Swallowing  |            |           | Blood in urine                    |            |           |
| <b>Respiratory</b>   |            |           | <b>Hematologic</b>                |            |           |
| Shortness of breath  |            |           | Sexual activity                   |            |           |
| Cough  |            |           | <b>Immunology</b>                 |            |           |
| Wheezing   |            |           | Breast lumps                      |            |           |
| <b>Cardiovascular</b>  |            |           | Nipple discharge                  |            |           |
| Chest pain   |            |           | Vaginal discharge/bleeding        |            |           |
| Leg swelling   |            |           | Last menstrual period             |            |           |
| Palpitations   |            |           | Age when periods began            |            |           |
| High blood pressure  |            |           | Number of pregnancies             |            |           |
| <b>Musculoskeletal</b>   |            |           | Number of live births             |            |           |
| Joint pain/arthritis   |            |           | <b>Neurologic</b>                 |            |           |
| Joint swelling   |            |           | Swollen lymph nodes               |            |           |
| Back pain  |            |           | Bruises/bleeds easily             |            |           |
| Problem walking  |            |           | <b>Psychiatric</b>                |            |           |
| <b>Skin</b>  |            |           | Rheumatoid arthritis              |            |           |
| Rash/itch  |            |           | Lupus                             |            |           |
| Wound  |            |           | Scleroderma                       |            |           |
| <b>Psychiatric</b>   |            |           | Numbness                          |            |           |
| Agitation  |            |           | Seizures                          |            |           |
| Confusion  |            |           | Speech difficulty                 |            |           |
| Depressed mood   |            |           | Fainting                          |            |           |
| Nervous/anxiety  |            |           | Weakness in arms or legs          |            |           |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_