Academic Surgical ASSOCIATES

Department of Surgical Oncology

Avo Artinyan, MD, MS, FACS

General Surgery/Surgical Oncology/Colorectal Surgery Intake Form

Patient Name _____ Date of Birth _____ Today's Date _____

CARE TEAM

Referring Physician _____ Specialty _____ Phone _____

Primary Care Physician _____ Phone _____

Cardiologist (if applicable) _____ Phone _____

Medical Oncologist (if applicable) _____ Phone _____

Radiation Oncologist (if applicable) _____ Phone _____

REASON FOR VISIT

_____

_____

What would you like to accomplish at this visit? _____

_____

MEDICAL HISTORY

Please check all the medical problems you have had now or in the past that you are aware of:

☐ No Major Medical Problems

☐ Heart Attack/Coronary Artery Disease ☐ Congestive Heart Failure ☐ Arrhythmia (Type: _____)
☐ Deep Vein Thrombosis (DVT) ☐ Pulmonary Embolism ☐ Emphysema (COPD)
☐ Kidney Disease (on dialysis? yes / no) ☐ Liver Disease/Hepatitis/Cirrhosis ☐ Stroke
☐ Diabetes ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol (Hypercholesterolemia)
☐ Heartburn/Reflux ☐ Cancer (Type:_____)
☐ Anxiety ☐ Arthritis ☐ Asthma
☐ Cataracts ☐ Depression ☐ Glaucoma
☐ Sleep Apnea ☐ Thyroid Disease (Hypothyroid/Hyperthyroid)
☐ Other_____

SURGICAL HISTORY

Please check all surgeries you have had in the past:

☐ No Surgeries

☐ Appendectomy ☐ Abdominal Surgery (Type: _____)
☐ Breast Surgery ☐ Hernia Surgery (Type: _____)
☐ C-Section ☐ Heart Bypass Surgery ☐ Hysterectomy
☐ Gallbladder Surgery ☐ Lung Surgery ☐ Prostatectomy
☐ Other_____

_____

Any difficulty with anesthesia? _____

Patient Name: _____ Date of Birth: _____

MEDICATIONS (Include prescriptions, herbal supplements, vitamins, etc.)

☐ No Medications

Name of medication *Dose* *Frequency*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergy History

☐ No Known Medication Allergy

Medication/Other Reaction

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Please CIRCLE if you have any of the following symptoms:

GENERAL	**EYES, EARS, NOSE, MOUTH**	**HEART**	**LUNGS**
Weakness	Vision change	Chest pain	Cough
Fatigue	Yellowing of eyes	Irregular heartbeat	Shortness of breath
Fever	Hearing changes	Palpitations	Pain with breathing
Sweats	Ringing in ears	Fainting episodes	Coughing blood
Weight loss	Hoarseness	Ankle swelling	Wheezing
Weight gain	Sore throat	Blood pressure problems	
Loss of appetite	Sinus infection		
	Mouth sores		

GASTROINTESTINAL		**GENITOURINARY**	**MUSCULOSKELETAL**
Abdominal pain	Heartburn	Painful urination	Arthritis
Distention	Nausea	Frequent urination	Stiffness
Vomiting	Blooding vomiting	Blood in urine	Arm swelling
Diarrhea	Constipation	Difficulty urinating	Leg swelling
Bloody stools	Black tarry stools	Urinary incontinence	Muscle weakness
White/chalky stools	Difficulty swallowing		Joint pain
Hemorrhoids	Rectal pain		Back pain
Incontinence	Rectal prolapse		Neck pain

HEMATOLOGIC/LYMPHATIC	**BREASTS**	**FEMALE REPRODUCTIVE**	**MALE REPRODUCTIVE**
Anemia	Mass/lump	Pelvic pain	Testicular pain
Easy bruising	Bloody discharge	Abnormal bleeding	Painful sex
Unusual bleeding	Pain	Sexual difficulty	Testicular swelling
Bleeding disorder	Skin changes	Painful sex	Erectile dysfunction
Repeated infections	Armpit lump/node	Irregular menses	Testicular mass
Lymph node swelling		Menopause	Abnormal discharge
Lymph node pain		Abnormal discharge	
		Hot flashes	
		Vaginal dryness	

SKIN	**NEUROLOGIC**	**ENDOCRINE**	**MENTAL HEALTH**
Itching	Headache	Heat intolerance	Anxiety
Rash	Seizure	Cold intolerance	Depression
Mole change	Dizziness	Excessive thirst	Confusion
Skin lesion	Tremors	Diabetes	PTSD
Yellowing of skin	Memory loss	Thyroid problems	Personality change
Pallor	Numbness		Suicidal thoughts
Mass/lesion	Tingling		Alcohol abuse
Changes in nails	Loss of consciousness		Drug abuse
Changes in hair	Focal weakness		

Patient Name: _____ Date of Birth: _____

CHEMOTHERAPY HISTORY (If applicable)

_____

_____

_____

RADIATION TREATMENT HISTORY (If applicable)

_____

_____

_____

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Please write in any immediate family member (parents, siblings, children) or second degree family member (e.g. grandparents, aunts, uncles) who has had the condition described. Include the age when first diagnosed.

Condition	Family Member	Age	Condition	Family Member	Age
Breast Cancer			Diabetes		
Colorectal Cancer			Stroke		
Ovarian Cancer			High Blood Pressure		
Prostate Cancer			High Cholesterol		
Stomach Cancer			Heart Disease/Heart Attack		
Melanoma			Diverticulitis		
Pancreas Cancer			Crohn's Disease/Ulcerative Colitis		
Lymphoma			Other		

SOCIAL HISTORY

Tobacco

Have you ever smoked? ☐ No

☐ Yes When did you start? _____ How many packs per day? _____

Have you quit smoking? ☐ No ☐ Yes When did you stop? _____

Do you use smokeless or other types of tobacco? ☐ No ☐ Yes

Alcohol

Do you drink alcohol currently? ☐ No

☐ Yes How many drinks containing alcohol do you consume in a week? _____
(1 drink = 1 glass of wine = 1 12oz can of beer = 1 shot of distilled liquor)

Have you consumed alcohol heavily in the past? ☐ No ☐ Yes

Other Recreational Drug Use _____

Patient Name: _____ Date of Birth: _____

Marital Status/Employment

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Number of children _____

Are you: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

What is/was your current or most recent occupation? _____

SCREENING EXAMS

Most recent date and result of following tests if available/applicable?

Colonoscopy _____

Mammogram (women) _____

PSA (men) _____

Skin cancer screening _____

OBSTETRIC AND GYNECOLOGIC HISTORY

☐ Not Applicable

How many pregnancies? _____ How many deliveries? _____

Date of last pregnancy _____ Date of last delivery _____

Are you menopausal? ☐ Yes, since what age _____ ☐ No

Age at first menstrual period _____ Date of last menstrual period _____

Have you taken birth control pills for more than 3 months in the past 10 years? ☐ Yes ☐ No

Have you taken estrogen or other female hormones in the last 10 years? ☐ Yes ☐ No

If yes, what did you take and for how long? _____

I have read, answered and understood all of the questions in my health inquiry form to the best of my ability. I understand that my good health care management depends on correct information.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____