Columbia Surgical Partners Intake Form

Name _____Date of Birth_____
Preferred pharmacy _____
Have you been seen here before? _____
Reason for visit _____
How long have you had this problem? _____
Primary Care Physician _____
Age _____ Height _____ Weight _____ In pain today? _____

Emergency contact
Name _____ Relationship _____
Best phone number _____ Alternative number _____

What **ILLNESSES** do you or have you had? Check all that apply.

__ Stroke
__ Heart disease
__ Lung disease
__ Gastric reflux
__ Bleeding problems
__Diverticulosis
__ Hemorrhoids
__ Cancer (type?)
__ Kidney failure
__ Thyroid disease
__ Stomach ulcers
__ HIV/AIDS
__ Parkinson's disease
__ Alzheimer's disease
__ Poor circulation
__ Liver problems
__ Blood clots
__ Aneurysm
__ Seizures
__ Hepatitis (A, B, C)
__ High cholesterol
__ High blood pressure
__ Diabetes
__ Other _____

What **SURGERIES** have you had? Check all that apply

__ Brain
__ Eyes, cataracts
__ Face, nose, ears
__ Tonsillectomy
__ Thyroid gland
__ Parathyroid glands
__ Lung
__ Heart
__ Breast
__ Appendectomy
__ Abdominal
__ Gallbladder
__ Hysterectomy/ovaries
__ Caesarean section
__ Kidney/bladder
__ Prostate
__ Dialysis access graft
__ Other _____
__ Aneurysm repair
__ Artery bypass
__ Carotid artery
__ Varicose veins
__ Amputation _____
__ Hernia repair _____
__ Hemorrhoidectomy
__ Pacemaker

When was your last colonoscopy? _____

What **MEDICINES** do you take? If you have a long list, please review with the nurse

_____ _____ __ Blood thinners
_____ _____ __ Over the counter meds
_____ _____ __ Insulin

Are you **ALLERGIC** to any medications? ☐No ☐Yes (please list medication and reaction)

_____

Do you have a **FAMILY HISTORY** of any of the following?

__ Heart disease
__ Cancer (What kind?)
___ Adopted/don't know family
__ High blood pressure
_____
Other _____
__ Diabetes

Do you **SMOKE?** ☐No ☐Yes ____ packs per day for ____ years. Quit ____ years ago
Vape? _____ Smokeless tobacco? _____ Marijuana? _____

Do you drink **ALCOHOL**? ____ No ___ Occasionally How much daily _____

Do you do **DRUGS**? ___ No ___ In the past ___ Currently (what kind?) _____

What is your **OCCUPATION**? __ None (__ retired __ disabled)
Type of work _____ Heavy lifting (>25lbs) _____

During the **PAST 6 MONTHS**, have you had any of the following problems? Check all that apply?

General
___ Fevers/chills
___ Weight loss (>20 lbs)
___ Night sweats
___ Decreased appetite
___ Recent foreign travel

Eyes
___ Double/blurred vision
___ Sudden loss of vision

Head and Neck
___ Neck mass/swelling
___ Headaches/migraines
___ Hearing loss
___ Frequent nosebleeds

Lungs
___ Shortness of breath
___ Cough
___ Wheezing
___ Pain with breathing
___ Sleep apnea ___ mask

Heart/Vascular

Gastrointestinal
___ Abdominal pain
___ Nausea/vomiting
___ Heartburn/reflux
___ Diarrhea
___ Constipation
___ Bloody/tarry stools
___ Crohns disease/colitis

Hematologic/Lymphatic
___ Bruise/ bleed easily
___ Swollen lymph nodes

Skin
___ Lumps/sores/ulcers
___ New/enlarging moles

Genitourinary
___ Blood in the urine
___ Burning urination
___ Leaking urine
___ Difficulty urinating
___ Erectile dysfunction

Musculoskeletal

Neurologic
___ Fainting/passing out
___ Difficulty walking
___ Paralysis (weak/numb)
___ Seizures
___ Dizziness

Endocrine
___ Heat/cold intolerance
___ Abnormal blood sugar
___ Change in hair/skin texture

Breast
___ Breast pain/soreness
___ Lumps in the breast
___ Nipple discharge
___ Nipple inversion

Psychiatric

___ Rapid/skipped beats
___ Chest pain
___ Vascular disease
___ Blood clots

___ Pain in joints
___ Muscle aches/cramps
___ Back pain
___ Fibromyalgia
___ Osteoporosis/penia

___ Depression
___ Frequent memory loss
___ Sleeping problems

New **BREAST** patients

Last mammogram? _____ Any abnormal mammograms? _____
Age of first period: _____
Number of pregnancies _____ Number of children _____
Age when first child was delivered _____
Any family history of breast cancer? _____ Ovarian cancer? _____

Do you **SMOKE?** ☐ No ☐ Yes
Menopause? Age at last period _____
Have you taken any of the following"
_____ Oral birth control pills
_____ IUD (Mirena) _____ Nexplanon/injectable device
_____ Hormone replacement (estrogen or progesterone?) ___ How many years?
Method of birth control _____
Hysterectomy (uterus removed) Y/N _____ Ovaries removed Y/N _____
Any prior biopsies? _____ History of atypical cells?
Any prior breast surgery? ___Implants ___ Reduction ____ Mass removal __ Cancer
Do you perform monthly self-breast exams? _____
Genetic testing (BRCA 1 or 2) in yourself or family members? _____
Personal history of breast cancer?
___ Surgery
___ Chemotherapy
___ Radiation

Are you having any of the following:

___ Breast pain/soreness
___ Breast skin changes

___ Nipple discharge
___ Breast dimpling

___ Breast mass
___ Axillary masses