Emerald Coast Cancer Center
1024 Mar Walt Drive
Fort Walton Beach, FL 32547

New Patient Information Form - Please Print Legibly

Today's Date: _____

Patient's Name: _____ Date Of Birth: _____

Home Address: _____ Social Security #: _____

_____ Male or Female _____

Mailing Address: _____ Home Phone #: _____

(If not same as Home) _____ Mobile Phone #: _____

_____ Work Phone #: _____

Marital Status Single _____ Married _____ Divorced _____ Separated _____

Widow _____ Significant Other _____

Email Address: _____

Place of Work _____ Employer Phone # _____

Did you graduate from: Grade School _____ High School _____ College _____ Graduate School _____

Advance Directives

Do you have a living will? Yes or No

Do you have a power of attorney? Yes or No

Do you have a DNR "Do not resuscitate"? Yes or No

Insurance Information

Primary Insurance _____ Employer _____

Policy # _____ Group Number _____

Policy Holder Name _____ Policy Holder SSN _____

Policy Holder Date of Birth _____

Secondary Insurance _____ Employer _____

Policy # _____ Group Number _____

Policy Holder Name _____ Policy Holder SSN _____

Policy Holder Date of Birth _____

Referring Doctor _____

Telephone # _____ Address(if not local) _____

Name Other Doctors

Physician Name: _____ Telephone #: _____

Physician Address (if not local): _____

Physician Name: _____ Telephone #: _____

Physician Address (if not local):

Describe your current problem in your own words: What medically bothers you? How and When did it start? Why are you referred to us?

Due to the nature of our specialty, we require a rather detailed history from our patients. The information requested below will be kept in the strictest confidence. Please be as thorough as possible so that we can provide you with the best possible care.

Please list all operations that you have had, including minor surgery:

Operation _____ Date _____ Surgeon _____

Operation _____ Date _____ Surgeon _____

Operation _____ Date _____ Surgeon _____

Operation _____ Date _____ Surgeon _____

Operation _____ Date _____ Surgeon _____

Have you every had Radiation Therapy treatments? If so, please list the date, amount/duration of therapy, the area of body that was radiated, and the name of the Radiotherapy center.

Area of Body _____ Date _____ Dosage _____ Radiotherapy Center _____

Area of Body _____ Date _____ Dosage _____ Radiotherapy Center _____

List all medications you are currently taking: Prescriptions, Over the Counter Medications, Vitamins, and etc…

Medication Name _____ Dose _____ (MG) Frequency _____
Reason Taken _____

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Reason Taken _____

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Reason Taken _____

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Reason Taken _____

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Reason Taken _____

Medication Name _____ Dose _____ (MG) Frequency _____
Reason Taken _____

Please provide your Pharmacy name and phone number for our records.

Pharmacy _____ Phone Number _____

Have you ever had an adverse reaction or allergic reaction to any medication or food? If so, Please list the agent and describe the reaction. If not, please write *"Never".*

List any medical problems you have now or have had in the past. (I.E. Diabetes, Ulcer, Heart Disease, Bleeding Problems)

Illness	Date of Onset	Treating MD
1		
2		
3		
4		
5		
6		

Have you ever been treated with hormones? _____

Were you ever exposed to toxic chemicals? _____

Have you traveled outside the U.S.? _____ If so, Where? _____

Have you ever had Tuberculosis (TB) ? _____ Has anyone close to you ever had TB? _____

Have you ever had a problem with drugs or alcohol? _____

If so, Describe: _____

Do you drink alcohol now? _____ If so, how much? _____

Do you drink coffee or tea? _____ If so, how much? _____

Have you ever smoked? _____ If so, how much? _____

Have you quit smoking? _____ If so, when? _____

Have you ever had a blood transfusion? _____

Please describe the circumstances: _____

Have you ever had a reaction to a blood transfusion? _____

Have you ever had psychiatric treatment or psychiatric hospitalization? _____

If so, please describe: _____

Have you ever take psychoactive medications? _____

If yes, please describe: _____

Family History

Has anyone in your family ever had cancer? _____

If so, List relationship to you and type of Cancer? _____

Is your mother alive? _____

If not, what did she die from and what age? _____

Does/Did she have any medical problems? _____ List Here: _____

Is your father alive? _____

If not, what did he die from and what age? _____

Does/Did she have any medical problems? _____ List Here: _____

How many brothers and sisters do you have? _____

Please list all serious illnesses that any of them has had _____

How many children do you have? _____

Please list all serious illnesses that any of them has had _____