Life Hope Building
3000 Medical Park Dr. Suite 495
Tampa, FL 33613

Appointment Scheduling

Life Hope Clinic (813) 259-0929 • Moffitt Cancer Center (813) 745-3980

New Patient Appointment Information

Clinic Appointment Date and Time ____

Referring Physician: ____
Address: ____
Phone Number: __________________________________

New Patient Questionnaire

Last Name ________________________________ First Name ________________________________

Address: ____ City __________________ State _____

Home Phone ________________________________ Cell Phone ________________________________

Date of birth _______________________________ Email _____________________________________

Present Illness:

Why are you seeing the Doctor today and how long have you had these symptoms?

____

____

____

Review of Systems (please circle any of the listed symptoms that are current problems for you)

Constitutional: Fever Chills Weight loss Weight gain Loss of Appetite Fatigue

Eyes: Pain Redness Double or Blurry Vision Dryness of eyes Glaucoma Glasses or Contacts

Ear, Nose, Throat: Sinusitis Hearing problems Ear ache Drainage Ringing in ears Sore Throat Nose Bleeds Nasal stuffiness Hoarseness

Cardiovascular: Chest Pain High Blood Pressure Palpitations Irregular heart beat Shortness of breath at rest Shortness of breath with exertion Leg Swelling

Respiratory: Shortness of Breath Asthma Cough Spitting up blood Wheezing Bronchitis Emphysema Pneumonia

Gastrointestinal: Heart burn Loss of appetite Nausea Vomiting Constipation Diarrhea Abdominal Pain Liver problems Heptatitis

Genitourinary: Frequent urination Painful or burning urination Incontinence Infections Irregular menses

Musculoskeletal: Joint pain or stiffness Weakness Swelling Back Pain Muscle Pain or stiffness

Skin: Rashes Ulcers Nail Changes Dryness Sores Itching

Breast: Lumps Pain Nipple Discharge Skin Changes/Thickening Fibrocystic Disease

Neurological: Fainting Seizures Paralysis Headaches Dizziness Loss of Balance Tremors Numbness

Psychological: Memory Loss Depression Insomnia Anxiety Mood Swings Memory Loss

Endocrine: Diabetes Thyroid Problems Excessive thirst / Urination / Sweating Hypoglycemia (Low Sugar)

Hematologic: Bleeding or bruising tendency Varicose veins Blood clots Lymphoma Anemia

Past Medical History (Please go through and check all boxes that apply to you. We are interested in knowing your CURRENT and PAST medical history)

Vision	Yes	No
1. Vision problems or eye disease?	☐	☐
2. Frequent headaches/Migraines?	☐	☐
3. Loss of vision in either eye?	☐	☐
4. Eye disease, glaucoma?	☐	☐
5. Eyeglasses?	☐	☐
6. Contact lenses?	☐	☐
7. Cataracts?	☐	☐
	☐	☐

Neurologic	Yes	No
1. Do you have any neurological disease?	☐	☐
2. Seizures (recent or previous)?	☐	☐
3. Spinal Cord Injury?	☐	☐
4. Numbness or tingling?	☐	☐
5. Head/spine surgery?	☐	☐
6. History of head trauma with persistent deficits?	☐	☐
7. Chronic recurring headaches (migraine)?	☐	☐
8. Brain tumor?	☐	☐
9. Loss of Memory?	☐	☐

Hearing	Yes	No
1. Do you have any hearing problems or ear disease?	☐	☐
2. Ringing in the ears?	☐	☐
3. Hearing Loss?	☐	☐
4. Ear infections or cold in the last 2 weeks?	☐	☐
5. Vertigo?	☐	☐

Endocrine	Yes	No
1. Do you have any endocrine (hormone) disease?	☐	☐
2. Diabetes (insulin requiring; units per day ______)?	☐	☐
3. Diabetes (non-insulin requiring)?	☐	☐
4. Childhood Onset Diabetes?	☐	☐
5. Thyroid Disease?	☐	☐
6. Obesity?	☐	☐
7. Unexplained weight loss or gain?	☐	☐

Heart	Yes	No
1. Do you have any of the folliwng: prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome?	☐	☐
2. Heart pain (Angina)?	☐	☐
3. Iirregular heart beat?	☐	☐

Dermatologic/Allergy	Yes	No
1. Do you have any skin or allergy diseases?	☐	☐
2. Sun sensitivity?	☐	☐
3. Allergic dermatitis to rubber or latex?	☐	☐

	Yes	No
4. History of Heart Attack?	☐	☐
5. Heart surgery?	☐	☐
6. High Blood Pressure?	☐	☐
7. Heart failure?	☐	☐
8. Stoke or Transient Ischemic Attack (TIA)?	☐	☐
9. Coronary Artery Blockage?	☐	☐
10. History of Stent?	☐	☐

	Yes	No
4. History of chronic dermatitis?	☐	☐
5. Active skin disease or infections?	☐	☐
6. Moles that have changed in size or color?	☐	☐
7. Allergies, including hay fever? (If so, to what?)	☐	☐

Vascular	Yes	No
1. Enlarged superficial veins or phlebitis?	☐	☐
2. Blood Clots?	☐	☐
3. Anemia?	☐	☐
4. Hardening of the arteries?	☐	☐
5. Aneurysms (Dilated arteries)?	☐	☐
6. Poor circulation of the hands or feet?	☐	☐
7. White fingers with cold or vibration?	☐	☐
8. Carotid artery blockage?	☐	☐

Autoimmune	Yes	No
1. Lupus?	☐	☐
2. Rheumatoid Arthrtis?	☐	☐
3. HIV/AIDS?	☐	☐
4. Hepatitis A?	☐	☐
5. Hepatitis B?	☐	☐
6. Hepatitis C?	☐	☐
7. Wound Healing Problems?	☐	☐
8. Collagen Disorder?	☐	☐

Respiratory	Yes	No
1. Do you have any respiratory (lung/airway) disease?	☐	☐
2. Asthma (including exercise induced asthma)?	☐	☐
3. Do you use an inhaler?	☐	☐
4. Bronchitis?	☐	☐
5. Emphysema?	☐	☐
6. Acute or chronic lung infections?	☐	☐
7. Persistent or recurring coughing or wheezing?	☐	☐
8. Wind pipe or lung surgery?	☐	☐
9. Collapsed lung?	☐	☐

Mental Health	Yes	No
1. Do you have any psychiatric or mental health problems?	☐	☐
2. History of psychosis?	☐	☐
3. Psychiatric/psychological consultation?	☐	☐
4. Difficulty dealing with stress?	☐	☐
5. Panic attacks, or anxiety or phobia disorder?	☐	☐
6. Periods of uncontrollable rage?	☐	☐
7. Diagnosed depression, personality disorder, or neuroses?	☐	☐

	Yes	No		Yes	No
10. Scoliosis (curved spine) with breathing limitations?	☐	☐			
11. History of Tuberculosis?	☐	☐			
12. Pulmonary Embolus	☐	☐			
Gastrointestinal			**Musculoskeletal**		
1. Do you have any stomach or intestinal disease?	☐	☐	1. Do you have any muscle or bone disease?	☐	☐
2. Hernias?	☐	☐	2. Severe joint paint, arthritis, tendonitis?	☐	☐
3. Colostomy?	☐	☐	3. Amputations?	☐	☐
4. Persistent stomach/abdominal pain or heartburn?	☐	☐	4. Loss of use of arm, leg, fingers, or toes?	☐	☐
			5. Loss of sensation?	☐	☐
5. Active ulcer disease?	☐	☐	6. Loss of strength in hands, arms, legs or feet?	☐	☐
6. Hepatitis or other liver disease?	☐	☐	7. Loss of coordination?	☐	☐
7. Ulcerative Colitis	☐	☐	8. Back injury?	☐	☐
8. Crohn's Disease	☐	☐	9. Chronic back pain?	☐	☐
			10. Are you RIGHT or LEFT handed?		
Genitourinary					
1. Blood in urine?	☐	☐			
2. Kidney Stones?	☐	☐			
3. Renal insufficiency?	☐	☐			
4. Renal Failure?	☐	☐			
5. Bladder Problems?	☐	☐			
6. Bladder or Kidney Cancer?	☐	☐			
7. Frequent Urinary Tract Infections	☐	☐			

Personal History of Cancers Other than Breast Cancer: ☐ **No** ☐ **Yes** ☐ **UNKNOWN**

If "YES", please enter the details here

1. ____

Year of diagnosis

____

Treatment:

☐ Chemotherapy ☐ Radiation ☐ None

2. ____

Year of diagnosis ______________

Treatment:
☐ Chemotherapy ☐ Radiation ☐ None

History of Surgeries Other than Breast Surgeries ☐ **No** ☐ **Yes** ☐ **Unknown**

If "Yes", please enter your last four (4) surgeries, starting with the most recent. Please include other surgeries for other cancers.

Date (mm/dd/yy)	Type of Surgery
1. ___/___/____	____
2. ___/___/____	____
3. ___/___/____	____
4. ___/___/____	____
5.___/___/____	____
6. ___/___/____	____

Breast History:

Past Episode of Breast Cancer: ☐ **No** ☐ **Yes**

If "YES", please enter the details here:

1. Type of breast Cancer:

☐ Lobular Carcinoma in-situ (LCIS)
☐ Ductal Carcinoma in-situ (DCIS)
☐ Other ______________________
☐ Invasive lobular
☐ Invasive ductal
☐ Unknown

Date of diagnosis (mm/dd/yy):
___/___/___

Side:
☐ Left ☐ Right ☐ Both ☐ Unknown

Treatment:
☐ Surgery ☐ Hormone Therapy
☐ Chemotherapy ☐ Radiation Therapy

2. Type of breast cancer:

☐ Lobular Carcinoma in-situ (LCIS)
☐ Ductal Carcinoma in-situ (DCIS)
☐ Other________________________
☐ Invasive lobular
☐ Invasive ductal
☐ Unknown

Date of diagnosis (mm/dd/yy):
___/___/___

Side:
☐ Left ☐ Right ☐ Both ☐ Unknown

Treatment:
☐ Surgery ☐ Hormone Therapy
☐ Chemotherapy ☐ Radiation Therapy

History of BREAST Surgery: ☐ **No** ☐ **Yes** ☐ **Unknown**

If "Yes", please enter your last two (2) breast surgeries

1. Date of surgery (mm/dd/yy):	Type of surgery:	Side:	Tumor type:	Treatment:
___/___/____	☐ Excisional Biopsy	☐ Left	☐ Benign	☐ Chemotherapy
Age at time of	☐ Core Biopsy	☐ Right	☐ Malignant	☐ Hormone Therapy

surgery: ______

☐ Lumpectomy ☐ Both ☐ Atypical ☐ Radiation Therapy
☐ Mastectomy ☐ No residual tumor
☐ Cyst Aspiration ☐ Unknown
☐ Implant (Augmentation or Reconstruction)
☐ Implant removal
☐ Reduction

2. Date of surgery (mm/dd/yy): ___/___/____
Age at time of Surgery: ______

Type of surgery:
☐ Excisional Biopsy
☐ Core Biopsy
☐ Lumpectomy
☐ Mastectomy
☐ Cyst Aspiration
☐ Implant (Augmentation or Reconstruction)
☐ Implant removal
☐ Reduction

Side:
☐ Left
☐ Right
☐ Both

Tumor type:
☐ Benign
☐ Malignant
☐ Atypical
☐ No residual tumor
☐ Unknown

Treatment:
☐ Chemotherapy
☐ Hormone Therapy
☐ Radiation Therapy

Family Medical History

	Age	Any Disease/ Conditions Past/Present	If deceased, cause of death
Father	_____	______________________________	________________________
Mother	_____	______________________________	________________________
Sibling	_____	______________________________	________________________
	_____	______________________________	________________________
	_____	______________________________	________________________
Child	_____	______________________________	________________________
	_____	______________________________	________________________

Current Medications:

Please list any medications you are now taking, including *vitamins* and *non-prescription* drugs. If additional space is needed, please attach a separate sheet listing the other medications.

	Medication	Dose (include units)	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

8. ____

9. ____

10. ____

Are you currently taking any of the following blood thinners? (Please circle all and any that apply)

Aspirin Plavix Warfarin (Coumadin) Fish Oil Fragmin

Dicumarol Miradon Clexane Arixta Orgaran

Innohep Argatroban Reludan Angiomax Pradax

Plavix Persantine Aggrenox

Allergy to Medications or Treatments: ☐ No ☐ Yes ☐ Unknown

Please list all known medications or treatments you are allergic to and the reaction you have. Also, include any reactions you have had to X-Ray contrast. If additional space is needed, please attach separate sheet.

Medication and/ or Treatments	Type of reaction (choose all that apply)
1. ______________	o Rash or hives o Nausea, vomiting or diarrhea o Light headed, low blood pressure, throat closed
2. ______________	o Rash or hives o Nausea, vomiting or diarrhea o Light headed, low blood pressure, throat closed
3. ______________	o Rash or hives o Nausea, vomiting or diarrhea o Light headed, low blood pressure, throat closed
4. ______________	o Rash or hives o Nausea, vomiting or diarrhea o Light headed, low blood pressure, throat closed

Patient Social History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Where were you born? ______________________

Where were you raised? ______________________

How many years have you been in Florida? ______________

Current Occupation: ______________________

Have you ever been a smoker? ☐ **No** ☐ **Yes**

If "yes", please answer the following:

Total years as a smoker: ___________

Packs per day: ___________

Date started: ___/___/____

If you have quit, please give the date stopped ___/___/____

Do you use nicotine vapors, nicotine gum, or any form of nicotine? o Never o Rarely o Moderately o Daily

Do you smoke Hooka, Cigars, or a Pipe? o Never o Rarely o Moderately o Daily

Do you drink alcoholic beverages? o Never o Rarely o Moderately o Daily

How many of drinks per week? ________________________

Do you drink caffeinated beverages? o No o Yes

Do you exercise? o No o Yes

Most common type of exercise_______________________________

Frequency of exercise _______________________ Days/week

Thank you for taking the time to fill this out. If you are seeing me for breast reconstruction, please take the time to read the information booklet on your options in breast reconstruction. I look forward to meeting you.

Sincerely,

Dunya M. Atisha, MD
Assistant Professor
University of South Florida
Division of Plastic Surgery
Tampa, FL