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)

	Yes	No		Yes	No
Vision			**Neurologic**		
1. Vision problems or eye disease?	☐	☐	1. Do you have any neurological disease?	☐	☐
2. Frequent headaches/Migraines?	☐	☐	2. Seizures (recent or previous)?	☐	☐
3. Loss of vision in either eye?	☐	☐	3. Spinal Cord Injury?	☐	☐
4. Eye disease, glaucoma?	☐	☐	4. Numbness or tingling?	☐	☐
5. Eyeglasses?	☐	☐	5. Head/spine surgery?	☐	☐
6. Contact lenses?	☐	☐	6. History of head trauma with persistent deficits?	☐	☐
7. Cataracts?	☐	☐	7. Chronic recurring headaches (migraine)?	☐	☐
			8. Brain tumor?	☐	☐
			9. Loss of Memory?	☐	☐
Hearing			**Endocrine**		
1. Do you have any hearing problems or ear disease?	☐	☐	1. Do you have any endocrine (hormone) disease?	☐	☐
2. Ringing in the ears?	☐	☐	2. Diabetes (insulin requiring; units per day _____)?	☐	☐
3. Hearing Loss?	☐	☐	3. Diabetes (non-insulin requiring)?	☐	☐
4. Ear infections or cold in the last 2 weeks?	☐	☐	4. Childhood Onset Diabetes?	☐	☐
5. Vertigo?	☐	☐	5. Thyroid Disease?	☐	☐
			6. Obesity?	☐	☐
			7. Unexplained weight loss or gain?	☐	☐
Heart			**Dermatologic/Allergy**		
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?	☐	☐	1. Do you have any skin or allergy diseases?	☐	☐
2. Heart pain (Angina)?	☐	☐	2. Sun sensitivity?	☐	☐
3. Iirregular heart beat?	☐	☐	3. Allergic dermatitis to rubber or latex?	☐	☐

	Yes	No		Yes	No
4. History of Heart Attack?	☐	☐	4. History of chronic dermatitis?	☐	☐
5. Heart surgery?	☐	☐	5. Active skin disease or infections?	☐	☐
6. High Blood Pressure?	☐	☐	6. Moles that have changed in size or color?	☐	☐
7. Heart failure?	☐	☐	**7.** Allergies, including hay fever? (If so, to what?)	☐	☐
8. Stoke or Transient Ischemic Attack (TIA)?	☐	☐			
9. Coronary Artery Blockage?	☐	☐			
10. History of Stent?	☐	☐			
Vascular			**Autoimmune**		
1. Enlarged superficial veins or phlebitis?	☐	☐	1. Lupus?	☐	☐
2. Blood Clots?	☐	☐	2. Rheumatoid Arthrtis?	☐	☐
3. Anemia?	☐	☐	3. HIV/AIDS?	☐	☐
4. Hardening of the arteries?	☐	☐	4. Hepatitis A?	☐	☐
5. Aneurysms (Dilated arteries)?	☐	☐	5. Hepatitis B?	☐	☐
6. Poor circulation of the hands or feet?	☐	☐	6. Hepatitis C?	☐	☐
7. White fingers with cold or vibration?	☐	☐	7. Wound Healing Problems?	☐	☐
8. Carotid artery blockage?	☐	☐	8. Collagen Disorder?	☐	☐
Respiratory			**Mental Health**		
1. Do you have any respiratory (lung/airway) disease?	☐	☐	1. Do you have any psychiatric or mental health problems?	☐	☐
2. Asthma (including exercise induced asthma)?	☐	☐	2. History of psychosis?	☐	☐
3. Do you use an inhaler?	☐	☐	3. Psychiatric/psychological consultation?	☐	☐
4. Bronchitis?	☐	☐	4. Difficulty dealing with stress?	☐	☐
5. Emphysema?	☐	☐	5. Panic attacks, or anxiety or phobia disorder?	☐	☐
6. Acute or chronic lung infections?	☐	☐	6. Periods of uncontrollable rage?	☐	☐
7. Persistent or recurring coughing or wheezing?	☐	☐	**7.** Diagnosed depression, personality disorder, or neuroses?	☐	☐
8. Wind pipe or lung surgery?	☐	☐			
9. Collapsed lung?	☐	☐			

	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. Active ulcer disease?	☐	☐	5. Loss of sensation?	☐	☐
6. Hepatitis or other liver disease?	☐	☐	6. Loss of strength in hands, arms, legs or feet?	☐	☐
7. Ulcerative Colitis	☐	☐	7. Loss of coordination?	☐	☐
8. Crohn's Disease	☐	☐	8. Back injury?	☐	☐
			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) □ Invasive lobular
□ Ductal Carcinoma in-situ (DCIS) □ Invasive ductal
□ Other _____ □ 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) □ Invasive lobular
□ Ductal Carcinoma in-situ (DCIS) □ Invasive ductal
□ Other_____ □ 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): Type of surgery: Side: Tumor type: Treatment:

___/___/____
Age at time of Surgery: _____

□ Excisional Biopsy □ Left □ Benign □ Chemotherapy
□ Core Biopsy □ Right □ Malignant □ Hormone Therapy
□ Lumpectomy □ Both □ Atypical □ Radiation Therapy
□ Mastectomy □ No residual tumor
□ Cyst Aspiration □ Unknown
□ Implant (Augmentation or Reconstruction)
□ Implant removal
□ Reduction

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