MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Today's Date			
Your Name			
Date of Birth	____/____/____ mm dd yyyy	Age	
Primary Race	☐ American Indian ☐ Asian ☐ Black/African-American ☐ Hispanic ☐ Other/Unknown ☐ White/Caucasian	Primary Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic

Preferred Phone #		Alternate Phone #		Work Phone #	
Email Address:					

Can we leave messages on the numbers listed above? ☐ Yes ☐ No

What is the best method to contact you? ☐ Phone ☐ Email

Emergency Contact #1

Name		Relationship	
Phone #			

Emergency Contact #2

Name		Relationship	
Phone #			

Previous Treatment Facilities and Physicians associated with consultations, treatment or follow up care related to your cancer and any other Physicians you regularly see:

1. Primary Oncologist:	Date:	
2. Internist:	Date:	
3.	Date:	
4.	Date:	
5.	Date:	
6.	Date:	

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Date	
Patient Name	
DOB	

Cancer Related Family History:

☐ Adopted

Family Member(s)	Type of Cancer	Deceased? If so, when?

Social History:

Do you have any children?	☐ Yes, How many? _____ ☐ No		
Do you now or have you ever smoked: ☐ Yes ☐ No *(skip the rest of this section)*	If yes, how long have/did you smoke?	_____ Years	
	If you quit, when?	_____ (Year)	
	What did you smoke and how much per day?	☐ Cigarettes # _____ packs per day ☐ Cigars # _____ per day ☐ Pipe: # _____ per day	
Do you drink any alcoholic beverages? ☐ Yes ☐ No *(skip the rest of this section)*	What do you drink?		
	How much do you drink on average?		
Do you use any recreational drugs? ☐ Yes ☐ No *(skip the rest of this section)*	What do you use?		
	How much do you use on average?		
Marital Status	☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Life Partner ☐ Widowed	Who do you live with?	
Are you currently working? ☐ Yes ☐ No	What kind of work do you or did you do?		
	Does your job limit your availability for appointments? ☐ Yes, please provide details ☐ No		

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Other:

Your Pharmacy Information

Pharmacy Name	
Pharmacy Number	

Your Medication List

Please Complete the Following or Attach a Medication List.

Drug Name	Dose	Frequency	Indication/Reason	Start Date

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Drug Name	Dose	Frequency	Indication/Reason	Start Date