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 ☐ Hawaiian/Pac Island ☐ Other/Unknown ☐ White/Caucasian		
Primary Ethinicity	☐ Hispanic or Latino ☐ Non-Hispanic	Gender	☐ Female ☐ Male ☐ Other: please specify:_____
Preferred Phone #		Alternate Phone #	
Email Address:			

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

What is the best method to contact you? ☐ Phone ☐ Email
Are you ok with us leaving a detailed message? ☐ Yes ☐ No
Are you ok with us sending you an email containing personal information? ☐ Yes ☐ No
*please note: your contact info will not be used for any unsolicited purposes**

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.	Date:	
3.	Date:	
4.	Date:	

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DOB	

Cancer Related Family History: ☐ Adopted		
Family Member(s)	Type of Cancer	Deceased? If so, when?

Reproductive/Sexual History:		
Do you have any children?	☐ Yes, How many? _____ ☐ No	
Number of births _____	Are you sexually active? ☐ Yes ☐ No	
What contraception do you currently use, if any?		

Social History:		
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 ☐ E – Cigarettes # _____ per week ☐ 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?	
Have you had the COVID-19 infection? ☐ Yes ☐ No *(skip the rest of this section)*	If yes, specify dates:	
Have you received the COVID-19 vaccine? ☐ Yes ☐ No *(skip the rest of this section)*	Manufacturer: Dates of Vaccination:	

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Have you received a COVID-19 booster? ☐ Yes ☐ No *(skip the rest of this section)*	Manufacturer: Dates of Vaccination:			
Marital Status	☐ Married ☐ Separated ☐ Life Partner	☐ Single ☐ Divorced ☐ 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			
Other:				

Your Pharmacy Information

Pharmacy Name	
Pharmacy Number	

Medication Allergies:

Drug Name	What Happens When You Take This Medicine?	Onset Date

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Your Medication List

Please Complete the Following or Attach a Medication List.

Drug Name	Dose	Frequency	Indication/Reason	Start Date