Gustave Roussy Cancer Campus
Request for an appointment

Patient Name: _____

Date of birth (MM/DD/YYYY): _____ ☐male ☐female

Address: _____

City / State / Zip Code: _____ Country: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Referred to Gustave Roussy Cancer hospital by: ☐self ☐primary care physician ☐referring physician

What is the main reason you are seeking consultation? What is the problem you are experiencing?
What part(s) of the body is (are) affected? What are the associated symptoms (e.g. itching, burning, bleeding, etc.)?
How long have you had this particular problem?
How often does the problem occur and how long does it last when it occurs?
What treatments have you already tried and what were the outcomes?

Pathology History (please list location on body and date of diagnosis/treatment) :

Has an immediate family member had the pathology or same problems? ☐yes ☐no
If yes, please complete the following:

Family member: Type of problem:

Any other pathology history we should know:

Medical & Social History

Height: Weight:

Do you have the following medical conditions?

Artificial heart valve ☐yes ☐no Cancer ☐yes ☐no Pacemaker/defibrillator ☐yes ☐no
Artificial joints ☐yes ☐no Depression ☐yes ☐no Stomach ulcers ☐yes ☐no
If yes, please list: Hay fever ☐yes ☐no Tuberculosis ☐yes ☐no
Asthma ☐yes ☐no Hepatitis ☐yes ☐no Other:
Autoimmune disease ☐yes ☐no Kidney problems ☐yes ☐no

Social History

Do you smoke? ☐yes ☐no If yes, how many packs per day (average)? _____
Do you drink alcohol? ☐yes ☐no If yes, how many drinks per week (average)? _____

What is your occupation (or former occupation if you are retired)?

Medications & Medication Allergies Please list medications you currently take:

1. Dose: Route (e.g. by mouth): Frequency:
2. Dose: Route (e.g. by mouth): Frequency:
3. Dose: Route (e.g. by mouth): Frequency:

Please use a separate sheet for additional medications.
I am allergic to the following medications:

☐None – no medication allergies Lidocaine ☐yes ☐no Iodine ☐yes ☐no
☐Other:

Signature of patient (or guardian if patient under 18 years):
Date: _____ Time: _____