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**COMMUNICATION ABOUT YOUR CARE**

*Concerned family members or friends often ask the physician and staff questions about your care. To protect your confidentiality, we will not discuss your care with anyone other than you, unless we have your permission to do so.*

I give Precision Cancer Care staff permission to disclose my protected health information to the following individuals. I understand that I can make changes to this list at any time by notifying a staff member:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship Phone Number­­­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone Number

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Name Relationship Phone Number

**LEAVING MESSAGES FOR YOU**

I give the Lawrence Cancer Center staff permission to leave messages at the following:

\_\_\_\_ Home / Work

\_\_\_\_ Cell Phone (Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_ Other Phone (Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian or DPOA Signature (if appropriate) Date

**This form was reviewed by patient on the following dates:**

Patient Initials: Date:

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

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**Patient Portal**

This program is a requirement by CMS (Medicare) to show that our Center is using the EHR technology in ways that can be measured significantly in quality and safety.

Part of the criteria is for patients to engage in using a Patient Portal. By doing this, patient will have access to clinical summaries, patient-specific education resources, secure electronic messaging, timely access to health information, and reminders for follow-up care.

What do we need from you? Only Two things:

1. An email address, and
2. The patient must log-in to activate their account.

Once you give us an email address we will enroll you in our Patient Portal. You will receive an email with instructions on how to activate your account.

Once your account is activated, you will receive your clinical summary information for any appointment you have with us and you will be able to email the staff questions or concerns. We also appreciate positive feedback.

All of this is voluntary and you have the right to Opt Out, but we are encouraging patients to help us meet our requirement. If you would like to participate please provide your email. We appreciate your help!

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I choose to Opt Out of the Patient Portal

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

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# **PATIENT DEMOGRAPHICS**

|  |
| --- |
| (Please Print) |
| **Today’s date:** | **Referring Physician:** |
| **PATIENT INFORMATION** |
| **Patient’s last name:** | **First:** | **Middle:** | **❑ Mr.****❑ Mrs.** | **❑ Miss****❑ Ms.** | **Marital status (circle one)** |
|  | Single / Mar / Div / Sep / Widow |
| **Is this your legal name?** | **If not, what is your legal name?** | **Height:** | **Birth date:** | **Age:** | **Sex:** |
| **❑ Yes** | **❑ No** |  **/ /** | **❑ M** | **❑ F** |
| **Email Address:** | **Social Security no.:** | **Children:** | **❑ Yes** | **❑ No** |
|  | **If yes how many?\_\_\_\_\_\_** |
| **Street Address:** | **Home phone no:** | **Cell phone no:** |
| ( ) | ( ) |
| P.O. box: | **City and State:** | **Zip Code:** | **Contact Preference:** |
|  |  |
| **Are you currently residing at a skilled nursing facility?** | ❑ Yes | ❑ No | Contact at Nursing Facility | Telephone no: |
| **Name of Facility** |  | ( ) |
| **Address of Nursing Facility:** |  |
|  |
|  | **Do you have available Transportation?** | ❑ Self | ❑ Yes | ❑ No |
| **Race:** | ❑ African American | ❑ Black | ❑ American Indian | ❑ Asian | ❑ Caucasian | ❑ Native Hawaiian | ❑ Other Pacific Island |
| **Ethnicity:** | ❑ Hispanic/Latino | ❑ Not Hispanic/Not Latino | **Language:** |
| **Medical Oncologist:** | **Surgeon(s):** | **PCP:** |
|  |  |  |
| **Pharmacy Name:** | **Location:** | **Pharmacy Phone:** |
| **INSURANCE INFORMATION** |
| (Please give your insurance card to the receptionist.) |
| **Occupation:**  | **Employer:** | **Employer address:** | **Employer phone no.:** |
| ( ) |
| Are you employed? ❑ Full Time ❑ Part Time | **Are you covered by insurance?** ❑ Yes ❑ No |
| **Please indicate primary insurance:** | ❑ Medicare | ❑ Medicare replacement | ❑ BCBS KS | ❑ BCBS Other | ❑ AETNA |
| ❑ CIGNA | ❑ UHC | ❑ Humana | ❑ Medicaid | ❑ Other |  |
| **Subscriber’s name:** | Subscriber’s S.S # | Birth date: / / | Group no.: | Policy no.: | Co-payment:$ |
| **Patient’s relationship to subscriber:** | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| **Name of secondary insurance (if applicable):** | **Subscriber’s name:** | **Group no.:** | **Policy no.:** |
| **Patient’s relationship to subscriber:** | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Precision Cancer Center or insurance company to release any information required to process my claims. |
|  | **Patient/Guardian signature** |  | **Date** |  |

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**II. HISTORY OF PRESENT ILLNESS:**

**CANCER – WHAT TYPE (S)**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DIAGNOSIS DATE(S)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EVER RECEIVED CHEMOTHERAPY OR RADIATION THERAPY?**  YES NO

MOST RECENT DATE RECEIVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOST RECENT DATE RECEIVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. MEDICAL & SURGICAL HISTORY:** *(PLEASE CHECK ALL THAT APPLY TO YOU)*

* AUTOIMMUNE DISORDERS
* BLOOD DISORDERS
* CATARACTS/GLAUCOMA
* CIRCULATION PROBLEMS
* COLON POLYPS
* DEPRESSION
* DIABETES
* DIVERTICULITIS
* HEARING LOSS
* HEART DISEASE/PROCEDURE
* HEMORRHOIDS
* HERNIAS
* HIGH BLOOD PRESSURE
* HIGH CHOLESTEROL
* HIV /AIDS
* JAUNDICE
* KIDNEY DISEASE
* LUNG DISORDERS
* MELANOMA
* MIGRAINES
* OSTEOARTHRITIS
* PACE MAKER
* SEIZURES
* SKIN CANCER
* STROKE
* SUNBURNS: EST # \_\_\_\_\_
* THYROID DISEASE

PLEASE LIST ANY OTHER SERIOUS ILLNESSES/DISEASES, INJURIES/ACCIDENTS, SURGERIES/PROCEDURES THAT REQUIRED HOSPITALIZATION OR TREATMENT:

DATE (MONTH/YEAR): SURGERIES OR HOSPITALIZATION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IV. GYN HISTORY: FEMALE PATIENTS ONLY**

ARE YOU OR COULD YOU BE PREGNANT? **YES NO**

AGE AT FIRST MENSTRUAL PERIOD: \_\_\_\_\_\_\_\_\_\_\_\_ DATE OF LAST MENSTRUAL PERIOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF LAST MAMMOGRAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF LAST PAP SMEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER USED ESTROGEN: **YES NO** HOW MANY YEARS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH CONTROL PILL USE: **YES NO** HOW MANY YEARS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUMBER OF PREGNANCIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE AT FIRST PREGNANCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUMBER OF CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADOPTED CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DID YOU BREAST FEED YOUR CHILDREN? **YES NO**

PAST SURGERY ON BREASTS? **YES NO** IF YES, WHAT TYPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HYSTERECTOMY? **YES NO** IF YES, WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**V. MEDICATIONS -** ATTACH LIST IF AVAILABLE - (INCLUDE VITAMINS, SUPPLEMENTS & ALTERNATIVE MEDICINES):

MEDICATION NAME: DOSE: HOW OFTEN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**VI. ALLERGIES:**

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, IODINE CONTRAST, OR SHELLFISH? **YES NO**

If yes, please list medications and the type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**VII. FAMILY HISTORY OF HEALTH PROBLEMS:** ARE YOU ADOPTED? YES NO

 (IF YES, PLEASE SKIP TO THE NEXT SECTION).

IN THE SPACES PROVIDED PLEASE INDICATE IF ANY OF YOUR FAMILY MEMBERS HAVE OR DID HAVE A HISTORY OF HEALTH PROBLEMS SUCH AS **CANCER**, HEART PROBLEMS, HIGH BLOOD PRESSURE, DIABETES, ETC. **(\*\*IT IS NOT NECESSARY TO LIST THEIR NAMES\*\*)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **LIVING STATUS**(ALIVE/DECEASED) | **AGE**(ALIVE/DECEASED) | **MEDICAL HISTORY** | **CANCER HISTORY** |
| MOTHER |  |  |  |  |
| **FATHER** |  |  |  |  |
| **SIBLINGS**(Brothers/Sisters) |  |  |  |  |
| **OTHER****RELATIVES** |  |  |  |  |

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VIII. SOCIAL HISTORY:**

**Any recent falls?** Yes or NO

**Use any assistive devices?** Wheelchair walker cane or NONE needed

**SMOKING STATUS**: SMOKER / NON-SMOKER **HAVE YOU SMOKED IN THE PAST**: Y N

 PAST TOBACCO USAGE: Years of Usage: \_\_\_\_\_\_\_\_\_\_\_ Pack(s) per Day: \_\_\_\_\_\_\_\_\_\_\_ Quit date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU USE ALCOHOL**? **YES NO** FREQUENCY & AMOUNT OF USE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN THE PAST YEAR HAVE YOU HAD YOUR FLU SHOT?** YES NO **PNEUMONIA SHOT?** YES NO

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed: Full time / Part time Disabled: Y N If Yes, Full / Partial Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU EXERCISE ROUTINELY? **YES NO**

If so, what Activity?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long & How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children (List Gender/Age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who Lives with You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you live?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IX. REVIEW OF SYSTEMS – (**refer to the ROS Checklist on the next page)

**CURRENT SYMPTOMS:** Are you experiencing any pain now? **Yes No** Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(no pain) (some pain) (very painful)**

 Level of pain: 0 1 2 3 4 5 6 7 8 9 10

**LAST DENTAL EXAM:** (Date) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Review of Systems**

**Vascular**

□ Calf pain with walking

□ Leg cramping

**Musculoskeletal**

□ Muscle or joint pain

□ Stiffness

□ Back pain

□ Redness of joints

□ Swelling of joints

□ Trauma

**Neurologic**

□ Dizziness

□ Fainting

□ Seizures

□ Weakness

□ Numbness

□ Tingling

□ Tremor

**Hematologic**

□ Easy bruising

□ Spontaneous bleeding

**Endocrine**

□ Heat or cold intolerance

□ Sweating

□ Frequent urination

□ Thirst

□ Change in appetite

**Psychiatric**

□ Nervousness

□ Stress

□ Depression

□ Memory loss

**Neck**

□ Lumps

□ Swollen glands

□ Pain

□ Stiffness

**Breasts**

□ Lumps

□ Pain

□ Discharge

□ Self-exams

□ Breast-feeding

□ Skin changes

**Respiratory**

□ Cough

□ Sputum

□ Coughing up blood

□ Shortness of breath

□ Wheezing

□ Painful breathing

□ Sleep apnea

**Cardiovascular**

□ Chest pain or discomfort

□ Tightness

□ Palpitations

□ Shortness of breath with activity

□ Difficulty breathing lying down

□ Swelling

□ Sudden awakening from sleep with shortness of breath

□ Pacemaker

**Gastrointestinal**

□ Swallowing difficulties

□ Heartburn

□ Change in appetite

□ Nausea

□ Change in bowel habits

□ Rectal bleeding

□ Constipation

□ Diarrhea

□ Yellow eyes or skin

**Urinary**

□ Frequency

□ Urgency

□ Burning or pain

□ Blood in urine

□ Incontinence

□ Change in urinary stream

**General**

□ Weight loss or gain

□ Fatigue

□ Fever or chills

□ Weakness

□ Insomnia

**Skin**

□ Rashes

□ Lumps

□ Itching

□ Dryness

□ Color changes

□ Hair and nail changes

**Head**

□ Headache

□ Head injury

□ Neck Pain

**Ears**

□ Decreased hearing

□ Ringing in ears

□ Earache

□ Drainage

**Eyes**

□ Vision Loss/Changes

□ Glasses or contacts

□ Pain

□ Redness

□ Blurry or double vision

□ Flashing lights

□ Specks

□ Glaucoma

□ Cataracts

□ Last eye exam \_\_\_\_\_\_\_\_\_\_

**Nose**

□ Stuffiness

□ Discharge

□ Itching

□ Hay fever

□ Nosebleeds

□ Sinus pain

**Throat**

□ Bleeding

□ Dentures

□ Sore tongue

□ Dry mouth

□ Sore throat

□ Hoarseness

□ Thrush

□ Non-healing sores