

# Welcome to CBCC

Thank you for considering Comprehensive Blood & Cancer Center (CBCC) for your medical care. Our goal is to provide you with the most advanced diagnostics and treatments available in the world. Our staff of physicians, nurses, therapists and assistants are dedicated to delivering your care in the most professional and compassionate way possible.

## New Patient Packet:

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We understand that having an illness is difficult for you and your family. Our physicians and staff are sensitive to this and are dedicated to helping you. When you arrive at CBCC, please sign-in with the receptionist. If for some reason you are unable to keep your scheduled appointment, please call as soon as possible to reschedule. This will allow us to use your time slot for another patient, and will permit you to receive the next earliest appointment time possible.

## What you need to bring:

- Please complete the required forms found in our packet and bring them with you to your scheduled appointment.
- Advanced Directive; Please bring a copy for us to place in your medical record.
- List of medications with dose and frequency and start date.
- Photo ID, such as a driver's license.
- List of allergies (med/food), reaction and date of first occurrence.
- Medical insurance card(s).

If you have any questions, please call us at: **(661) 322-2206**.



- (A) Building A**
  - Breast Health Center
  - Dignity Health Infusion Center
  - Dispensary
  - Health & Wellness Café
  - Medical Assistants
  - Medical Records
  - Receptionist
  - RNs, PAs, Drs
  - Scheduling

- (B) Building B**
  - First Floor:*
    - Dermatology & Laser Center
  - Second Floor:*
    - Business Billing
    - Global Research
    - Human Resources
    - Quality Assurance

- (C) Building C**
  - Cyberknife®

## Directions to CBCC

We are located on the south side of Truxtun Avenue across the street from the Truxtun Lake, between Mohawk and Coffee Road.

From Highway 99 southbound, take the California Avenue exit, turn left on California, then left on Oak Street, go to Truxtun Avenue (first stop light), turn left and go about 3 miles. Turn left on Truxtun Plaza West and turn right into the first parking lot and continue back to the one story building.

From Highway 99 northbound, take the California Avenue Exit, turn right on California, then left on Oak Street, go to Truxtun Avenue (first stop light), turn left and go about three miles, we are on the left (south) side.

# Attention All Patients

## Check-In Information & Late Policy

We understand that many of you have taken time off from work or school in order to come in for your appointment. We also realize that you have responsibilities to which you must attend. In an effort to maximize the time you spend with the provider during the visit; our late policy is as follows.

**Purpose:** To create a more professional environment for our patients and staff and to ensure all of our patients get the most out of their visit. Please understand that we will do our best to accommodate you and will be happy to reschedule appointments as necessary.

1. We recommend you arrive 15 minutes prior to your scheduled appointment to allow ample time for the check in process.

**New patients:** We recommend that you arrive at least 30 minutes prior to your appointment time in order to ensure that we have all of your necessary paperwork and documents.

2. **Please be aware that arriving after your scheduled appointment time may require rescheduling depending on the clinic volume that day.**

We strive to make everyone's visit comfortable and within an appropriate amount of time. Please assist us in reaching this goal by being at your appointment on time. If you have any problems with your appointment time or need to reschedule, please call: **(661) 322-2206**.

We look forward to serving you and making your office visit a pleasant one.

### CBCC Policy on Children & Visitors

**Visitors:** Space at CBCC is limited. Please only bring 1 (one) visitor to your appointment.

**Exposure: Please do not bring pregnant women or children under 16 to your appointment.** They should not be exposed to chemotherapy drugs and radioactive agents.

### CBCC Policy on Appointments

The CBCC staff focus very hard on being respectful of your time. As such, we encourage you to keep all of your scheduled appointments.

The staff also understands that from time to time patients need immediate attention for medical conditions they are being treated for at CBCC. In such situations, please call us before coming to the facility, so that we can expedite the scheduling of your visit and limit your wait.

# Code of Conduct

CBCC is committed to ensuring a safe, secure and respectful environment for everyone – patients, visitors, physicians, providers, healthcare teams and employees.

**It is our expectation that all individuals will demonstrate civil and respectful behavior while on our premises.**

**We expressly prohibit:**

- Abusive language including threats and slurs
- Sexual harassment
- Physical assault
- Weapons

To maintain a safe, secure and respectful environment for all, we reserve the right to take appropriate measures to address abusive, disruptive, inappropriate or aggressive behavior.

Your signature below indicates that you have read and agree to CBCC's Code of Conduct.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# Prescription Refill Policy

- To **request a refill** call your pharmacy 72 hours prior to your last dose.
- For outside prescriptions (prescriptions not filled by CBCC) your pharmacy will send an electronic request to your provider.
- **Please do not** call CBCC, your physician's office will respond to the pharmacy request.
- To change a prescription call CBCC and ask for your physician's office.  
Do **not** call your pharmacy.
- Leave a message with your name, date of birth and prescription request.
- If your request is approved the prescription will be sent to your pharmacy. If it is **not** approved your physician's office will call you.
- Messages are checked every two hours –**Please do not** call back to inquire about your prescription.

## DEA Schedule II Drugs

Codeine	Oxycodone	Fentanyl	Morphine
MSContin	Thylox	Percocet	Roxanol
Seconal	Dilaudid	Hydrocodone	
Demerol	Oxycontin	Methadone	

- **Must be sent via secure electronic prescription.** Limited to a 30 day supply with no refills.
- To request another 30 day supply or to request a change in your medication call CBCC **at least 72 hours prior to your last dose** and ask for your physician's office.
- Leave a message with your name, date of birth and prescription request.
- Call Monday and your pharmacy should receive by Thursday.
- Call Tuesday and your pharmacy should receive by Friday.
- Call Wednesday and your pharmacy should receive by Monday.
- Call Thursday and your pharmacy should receive by Tuesday.
- Call Friday and your pharmacy should receive by Wednesday.
- If your request is **not** approved, your physician's office will call you.

## Requesting Medical Records, CD's, or Physicians Letters

For any medical records, imaging CD's or physician letters please call **(661) 322-2206**. Please allow up to 48 hours for your request to be processed. In the event that your request will take longer, CBCC will notify you.

We understand that sometimes these are needed urgently and in these situations we will do our best to accommodate your request.

# Patient Information Form

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Sex:  Male  Female

Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

If Student, Name of School: \_\_\_\_\_

Language(s) Spoken: \_\_\_\_\_

Race:  White  Black  Asian  Hispanic  
 Native Hawaiian  Pacific Islander  
 Native American or Alaskan Native  
 Decline to Answer  
 Other: \_\_\_\_\_

## Spouse or Responsible Party:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

## Person to Contact in Case of Emergency:

Permission to discuss my treatment, diagnostic tests and medical condition:

Yes  No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Please bring your insurance card(s) and your prescription card with you to present to the receptionist when you arrive for your appointment.**

**Prescription Drugs:** To better meet our patients' needs we can dispense some of the prescriptions as prescribed by our physician(s) here on our campus. We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and that you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

**Notice to Consumers:** Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 or [www.mbc.ca.gov](http://www.mbc.ca.gov)

Date: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**CBCC** COMPREHENSIVE  
BLOOD & CANCER CENTER  
*Outsmarting Cancer™*

(661) 322-2206 main | (661) 322-7027 fax | 6501 Truxtun Avenue, Bakersfield, CA 93309 | [www.cbccusa.com](http://www.cbccusa.com)

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# Request for Release of Medical Records & Pathology Material

**URGENT**

Physician/Hospital Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient or Guardian Signature: \_\_\_\_\_

\_\_\_\_\_  
Guardian Name: \_\_\_\_\_

Dates of Hospitalization: \_\_\_\_\_ thru \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I hereby request any and all of the following medical records in your possession:

- Imaging Reports
- Laboratory & Pathology Results
- Pathology Material
- Physicians Office Records
- Hospital Records
- HIV Test Results
- Mental Health Records Protected by Lanterman-Petris - Short Act
- Other: \_\_\_\_\_

To be released and faxed to:

Comprehensive Blood & Cancer Center  
6501 Truxtun Avenue  
Bakersfield, CA 93309  
Fax: **(661) 322-7027**

The authorization is effective now and will remain in effect until one year from date signed.

If not signed by patient, please indicate the relationship:

- Parent or guardian of a minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of a deceased patient
- Spouse or person financially responsible - where information is solely for the purpose of processing an application for dependent health care coverage

For mental health records only:

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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# Consent to Obtain Patient Medication History

Your patient medication history is an important part of helping our providers treat your symptoms and/or illness properly and avoiding potentially dangerous drug interactions. Your medication history has been compiled from a variety of sources including, but not limited to, pharmacies, insurance companies and other healthcare providers. This information is stored in the electronic medical records (EHR/EMR) and is considered part of your medical record.

It is important that you discuss your medication history with your provider. While most of your medication history will be available, there are instances where items may not be available including, but not limited to, drugs that were purchased without using insurance, over-the-counter drugs, supplements and pharmacies that do not make medication history available.

By signing below I hereby give my permission to allow CBCC and its provider(s) to obtain my medication history. I understand that I am giving my consent for CBCC to collect and giving my pharmacy, insurance plans and other entities permission to disclose information about my medication history which may include, but not be limited to, medications to treat AIDS/HIV and medications prescribed to treat mental health issues such as depression.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



# Release of Patient Medical Information

\_\_\_\_\_  
(Initial) I give the physicians and staff of CBCC permission to discuss my treatment, diagnostic tests, medical condition with the following individuals:

\_\_\_\_\_  
(Initial) I give the physicians and staff of CBCC permission to discuss my Mental Health Records protected by Lanterman-Petris -Short Act with the following individuals:

**Release Information to:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Release Information to:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Release Information to:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Release Information to:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

*I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.*

I authorize CBCC to leave test results on my voice mail:

Yes  No

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

I authorize CBCC to fax test results to me:

Yes  No

Fax Number: \_\_\_\_\_

*I understand that if my telephone or fax number changes from this list that I must notify CBCC in writing.*

**This is an indefinite consent form unless otherwise specified.**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# HIPAA Notice of Privacy Practices (NPP)

HIPAA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit disclosure of protected health information, which is any data concerning your treatment in the office. We will make every effort to comply completely with all HIPAA privacy regulations except as otherwise consented to by yourself, as set forth below. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our practice Privacy Officer.

## Our Obligations:

We are required by law to:

- Maintain the privacy of protected health information except as described below.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

## How we may use and disclose health information:

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

**For Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**For Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an Insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

**For Screening.** We may use and disclose health information pertaining to your diagnosis, care and treatment to CBCC Global, Inc. and any other CBCC affiliated entity including its agents and employees, for the purpose of cancer-related research and/or determining possible eligibility in cancer chemotherapy trials now in existence or which may arise in the future. Such screening is typically performed over time and on a random basis as new trials, protocols or experimental treatments come into existence. You will not be enrolled in any such program without your express consent and upon further discussion with your physician. Screening promotes better care for patients since new treatments may be found which did not exist when a patient was initially diagnosed and/or treated for cancer.

**Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or conditions and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** We may use or disclose you Protected health information to provide legally required notices or unauthorized access to or disclosure of you health information.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discover request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

## **Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form and Consent to CBCC HIPAA Policies**

Effective April 14, 2003; the law requires that Comprehensive Blood & Cancer Center provide to our patients a copy of its Notice of Privacy Practices for Health Information. By signing below, the patient acknowledges consent and receipt of such, or if you are the patient's personal representative, or authorized agent or involved in patient's medical care, you acknowledge consent and receipt of such.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Guardian Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# Patient Financial Responsibility Assignments of Benefits

## Patient Financial Responsibility Assignment of Benefits

Medicare and private insurance companies may not entirely cover the services requested by your physician and they may only pay a portion of the amount that CBCC bills to them. For example, patients are typically responsible for paying deductibles, co-insurance, and co-payments. By signing the Form you acknowledge that you are responsible for the amounts not paid by Medicare and/or your insurance company. By signing you also agree to meet with the CBCC Financial Counselor to arrange a payment plan for any outstanding balances. The counselor will work with you to make these payments as easy as possible on you and your family.

CBCC will make every effort to obtain authorization for services ordered by your physician from Medicare and/or your private insurance company. By signing this form you authorize CBCC to appeal any denials for prior authorization of services on your behalf.

We will also bill Medicare and/or your insurer for the services that we provide. By signing this form you authorize that payment of insurance benefits to CBCC for the services provided to you.

By signing the form you also authorize the release of medical information to your insurance company and to any other physicians participating in your medical care.

**PET Scans:** For patients receiving PET scans there is an additional obligation. Since the materials used in the PET scan must be specifically ordered for each patient, ***PET scans may only be canceled up to 24 hours before the exam is scheduled. After this time period, patients canceling a PET scan will be charged the cost of the unused dose.***

## Insurance Eligibility Certification

I understand that it is my responsibility to provide CBCC with accurate information regarding my Medical Insurance Coverage. Should there be any change in my coverage, I agree that I am responsible for notifying CBCC of the changes and understand that should I fail to do so, I will be financially responsible for any resulting unpaid claims.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# CBCC Payment Policies

## CBCC Collection Policy

### Cash Pay:

- Payment in full is due at the time services are rendered.
- The patient is requested to keep an authorized credit card on file. In the event there is an unpaid balance at the time of monthly billing, this balance can be transferred to the credit card. A courtesy call will be made to the patient to arrange this transaction.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

### Medicare with no Secondary Insurance:

- CBCC accepts Medicare assignment.
- The patient is responsible for payment of any deductible amount, 20% co-insurance and any non-covered services for which an Advanced Beneficiary Notice has been signed.
- Payment is due in full upon receipt of the monthly statement.
- The patient is requested to keep an authorized credit card on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

### Medicare with Secondary Insurance:

- CBCC accepts Medicare assignment.
- Secondary insurance will be verified for coverage. If appropriate coverage exists, CBCC will bill the supplemental plan.
- All co-pays are due at the time of service.
- The patient is responsible for any balance unpaid by the supplemental plan and any non-covered services for which an Advanced Beneficiary Notice has been signed. This payment is due in full upon receipt of the monthly statement.

### Commercial Insurance:

- Insurance plans will be verified for coverage. If appropriate coverage exists, CBCC will bill the plan(s).
- All co-pays are due at the time of service.
- The patient is responsible for any balance due after payment by the insurance plan(s).
- Payment is due in full upon receipt of the monthly statement.
- The patient is requested to keep an authorized credit card on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

### Medical Share of Cost:

- Until the share of cost is met, the cash pay policy will be followed.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# Financial Liaison Letter

Dear Patient,

Hello my name is Yazmin Irizarry I am the Financial Counselor here at CBCC & Dignity Health Care. It is my goal to make sure you have a better understanding of your Medical coverage as well as your financial responsibility.

**Have you wondered** - Is my treatment covered and what will my financial responsibility be? If so, please do not hesitate to call or meet with me: please allow me to assist you with your financial questions.

Not sure if you qualify for Financial Assistance, it only takes a moment of your time. There are several drug manufacture co-pay programs for the commercially insured; and foundation programs for those with Government insurance.

These programs may assist with your radiation, injections, Infusion and chemotherapy needs. I can also provide telephone numbers for additional assistance should you require services beyond my capabilities.

Please do not hesitate to contact me **(661) 616-6443**.

Kindest regards,

**Yazmin Irizarry**

*Financial Counselor*

(661) 616-6443

(661) 616-6443 Fax

yirizarry@cbccusa.com

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# Patient Health & Medical History Questionnaire

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Age: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_

Last Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Sex:  Male  Female

Please answer carefully the enclosed questionnaire about your present and past medical problems and the history of your current illness. It is important that you complete each of the questions as accurately as possible so the doctor can best understand the nature of your present medical problems.

This information will become part of your permanent record and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

## List Your Physician(s)

Use additional pages if needed. Check box if provider is to receive a copy of today's consultation.

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Phone: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pulmonologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Urologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Gastroenterologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_

## Your Pharmacy

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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## History of Present Illness

Physician Comments

What is the reason for your visit? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your current symptoms and how long have you had them? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you received treatment for this diagnosis?

No  Yes. Please give date and location of the treatment/surgery:

Surgery: \_\_\_\_\_

Radiation: \_\_\_\_\_

Drug or other therapy (chemotherapy): \_\_\_\_\_

Do you have other medical problems that are now being treated?

No  Yes. Please list them here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Past Medical History

Check the illnesses that you have had or currently have. Provide the year for those that required hospitalization:

Heart Disease \_\_\_\_\_  Scarlet Fever \_\_\_\_\_  Kidney Disease \_\_\_\_\_

Cancer \_\_\_\_\_  Hepatitis \_\_\_\_\_  Bronchitis (*Recurring*) \_\_\_\_\_

Diabetes \_\_\_\_\_  Stomach Ulcer \_\_\_\_\_  Venereal Disease \_\_\_\_\_

Emphysema \_\_\_\_\_  Liver Disease \_\_\_\_\_  Nervous Breakdown \_\_\_\_\_

Hives \_\_\_\_\_  Jaundice \_\_\_\_\_  Bleeding Disorder \_\_\_\_\_

Asthma \_\_\_\_\_  Measles \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_

Tuberculosis \_\_\_\_\_  Mumps \_\_\_\_\_  High Blood Pressure \_\_\_\_\_

Valley Fever \_\_\_\_\_  Chicken Pox \_\_\_\_\_  Shingles \_\_\_\_\_

Blood Clots \_\_\_\_\_  Anemia \_\_\_\_\_  Herpes Zoster \_\_\_\_\_

Seizures \_\_\_\_\_  Pneumonia (*Recurring*) \_\_\_\_\_  Thyroid Disease \_\_\_\_\_

Other serious illness: \_\_\_\_\_

Have you had any of the surgeries listed below? Check and give the year:

Appendix \_\_\_\_\_  Stomach \_\_\_\_\_  Bladder \_\_\_\_\_

Breast \_\_\_\_\_  Artery \_\_\_\_\_  Heart Problems \_\_\_\_\_

Eyes \_\_\_\_\_  Colon \_\_\_\_\_  Heart Surgery \_\_\_\_\_



## Past Medical History (cont.)

Physician Comments

Have you had any of the surgeries listed below? Check and give the year:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hip _____         | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Hernia Repair _____          |
| <input type="checkbox"/> Lung _____        | <input type="checkbox"/> Knee _____        | <input type="checkbox"/> Prostate Gland _____         |
| <input type="checkbox"/> Ovary _____       | <input type="checkbox"/> Mastoids _____    | <input type="checkbox"/> Thyroid Gland _____          |
| <input type="checkbox"/> Kidney _____      | <input type="checkbox"/> Nose _____        | <input type="checkbox"/> Hemorrhoids _____            |
| <input type="checkbox"/> Veins _____       | <input type="checkbox"/> Tubes Tied _____  | <input type="checkbox"/> Tonsil & Adenoids _____      |
| <input type="checkbox"/> Bone Marrow _____ | <input type="checkbox"/> Uterus _____      | <input type="checkbox"/> Dilatation & Curettage _____ |

Other surgeries: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had problems with anesthesia?

- No  Yes: Please state the problem: \_\_\_\_\_

Have you ever had radiation treatment?

- No  Yes: What part(s) of the body: \_\_\_\_\_

Have you ever had serious accidents or injuries?

- No  Yes: Please describe: \_\_\_\_\_

Have you ever had blood transfusions?

- No  Yes: List how many: \_\_\_\_\_

## Medications

List the names of any medications that you take regularly:

Name:	Dose:	Frequency:	Date Started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Would you like to have some of your prescriptions filled at our office?  No  Yes

## Vaccination Information

### Flu Shot

Date Taken: \_\_\_\_\_ Location:  Left Arm  Right Arm

### Covid-19

1st Dose: \_\_\_\_\_ Location:  Left Arm  Right Arm

2nd Dose: \_\_\_\_\_ Location:  Left Arm  Right Arm

Booster: \_\_\_\_\_ Location:  Left Arm  Right Arm

Manufacturer:  Moderna  Pfizer  Johnson & Johnson

Allergies

Medication/Food:	Reaction:	Date First Occurred:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Habits

List the jobs you have held: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been exposed to any of the following?

- Radiation  No  Yes
- Petroleum Products  No  Yes
- Industrial Toxins  No  Yes
- Insecticides  No  Yes
- Benzene  No  Yes

Smoking:

- Yes, current every day smoker. Number of years: \_\_\_\_\_ Packs per day: \_\_\_\_\_
- Yes, occasional smoker. Number of years: \_\_\_\_\_ Packs per week: \_\_\_\_\_
- Previously smoked, but quit. Years quit: \_\_\_\_\_
- Never smoked

Do you drink alcohol?  No  Yes: List amount & type: \_\_\_\_\_

Have you been on a diet in the past?  No  Yes: List type and reason: \_\_\_\_\_

Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)?  No  Yes

Religious Beliefs (optional)

Do you have a religious background?  No  Yes: Explain: \_\_\_\_\_

Will your religious beliefs have an important role in your treatment?  No  Yes

Would you like a doctor, nurse or other staff member to pray with you?  No  Yes

Cancer Screening

Have you had any of the following tests? If yes, when and where?

- Mammogram  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Pap Smear  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Prostate Exam  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- PSA  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Colon Exam  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Skin Exam  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Chest X-Ray  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_
- Other: \_\_\_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

## General Health Family History

## Physician Comments

List the members of your immediate family, their ages, current health status and if deceased, their age of death.

	Age	Health Status			Cause of Death & Age
		Good	Fair	Poor	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

List others here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you of Ashkenazi Jewish heritage?  No  Yes

Has any family member had a blood disease?

No  Yes: List relationship and type of blood disease: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any birth defects in your family history?

No  Yes: Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you a twin?  No  Yes

Were you born with a birth defect?

No  Yes: Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Cancer Family History

# Physician Comments

Write in the **age** of each cancer diagnosis in the box below for yourself and each family member who has been diagnosed with cancer as indicated.

	Other Fill in cancer type & age diagnosed.	Ovarian Cancer	Endometrial Cancer	Pancreatic Cancer	Prostate Cancer	Colon Cancer	Male Breast Cancer	Breast Cancer
Yourself								
Mother								
Father								
Sister(s)								
Brother(s)								
Daughter(s)								
Son(s)								
<b>MOTHER'S SIDE</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								
<b>FATHER'S SIDE</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								

Family history unknown.

## Review of Systems

## Physician Comments

Do you have, or have you had *in the last 6 months*, any of the following?

General weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin rashes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in taste	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sores not healing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever of unknown cause	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weight loss without cause	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Enlarging moles	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Night sweats	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chills	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Loss of appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have frequent/recurring headaches?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have frequent dizzy spells?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever fainted?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had a recent change in eyesight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had a recent change in hearing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have ringing or roaring in your ears?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you wear dentures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do they fit properly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have frequent soar throats?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have trouble swallowing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have hoarseness without colds?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you lumps or swelling in the neck?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you cough up a lot of phlegm?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you coughed up blood?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have coughing spells?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have shortness of breath without exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have shortness of breath with exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had pains in your chest?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you been treated for heart problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had high blood pressure?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had thumping or racing heart?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do your ankles swell?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have frequent indigestion?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have pain in your stomach?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had frequent nausea or vomiting?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever vomited blood?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had black bowel movements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

## Review of Systems (cont.)

Physician Comments

Do you **currently** have any of the following?

- Have your bowel movements changed in the last 6 months?  No  Yes
- Have you had blood in your bowel movements?  No  Yes
- Do you notice burning on urination?  No  Yes
- Do you get up every night to urinate?  No  Yes
- Have you passed blood in urine?  No  Yes
- Have you passed a kidney stone?  No  Yes
- Have you had root beer colored urine?  No  Yes
- Any change in your desire for sexual activity?  No  Yes
- Any change in your ability to engage in sexual activity?  No  Yes
- Do you have joint trouble?  No  Yes
- Do you have constant back pain?  No  Yes
- Do you have constant bone pain?  No  Yes
- Do you bruise easily?  No  Yes
- Do you bleed easily?  No  Yes
- Do your gums bleed frequently?  No  Yes
- Do you have prolonged bleeding with cuts?  No  Yes
- Do you have frequent nosebleeds?  No  Yes
- Do you have feelings of sadness, depression or anxiety?  No  Yes

### FOR MEN ONLY

- Do you have trouble urinating?  No  Yes
- Have you been told you have prostate problems?  No  Yes
- Have you been circumcised?  No  Yes

### Breast Health History (Women Only)

- Do you conduct breast self exams?  No  Yes
- Do you feel palpable lumps?  No  Right  Left  Both
- Do you have nipple discharge?  No  Right  Left  Both
- Do you have nipple inversion?  No  Right  Left  Both
- Has the size or shape of the nipples changed?  No  Right  Left  Both
- Have you had any breast trauma?  No  Right  Left  Both
- Have you had any breast cyst aspirated?  No  Right  Left  Both
- Do you feel breast pain?  No  Right  Left  Both
- If yes, is the pain related to periods?  No  Yes
- Have you had any prior breast surgery?  No  Yes

Type of surgery:  Biopsy  Lumpectomy  Mastectomy

If yes, check which side and list diagnosis year and where the surgery was performed:

Left Diagnosis, list year: \_\_\_\_\_, where: \_\_\_\_\_

Right Diagnosis, list year: \_\_\_\_\_, where: \_\_\_\_\_

## Gynecologic History (Women Only)

Physician Comments

Have you ever taken hormones?  No  Yes

If yes, give type: \_\_\_\_\_ Duration: \_\_\_\_\_ Stopped: \_\_\_\_\_

Have you ever taken birth control pills?  No  Yes

If yes, when were they started? \_\_\_\_\_ When were they stopped? \_\_\_\_\_

How old were you when you began menstruating? \_\_\_\_\_

Do you bleed between your periods?  No  Yes

Do you still have periods?

Yes, indicate date of first day of last period: \_\_\_\_\_

No, check reason:  Natural, at what age? \_\_\_\_\_  Surgery, at what age? \_\_\_\_\_

Are you currently pregnant?  No  Yes

Are you interested in having more children?  No  Yes

Age when you first became pregnant with your first full-term pregnancy? \_\_\_\_\_

Have you had any complications of pregnancy?  No  Yes, describe: \_\_\_\_\_

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Did you breast feed?  No  Yes, for \_\_\_\_\_ months.

Please indicate the following:

Number of pregnancies: \_\_\_\_\_ Number of premature births: \_\_\_\_\_

Number of cesareans: \_\_\_\_\_ Number of abortions: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Number of children born alive: \_\_\_\_\_

Number of stillborn: \_\_\_\_\_