

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Instructions: Please answer these questions as accurately as possible. This will help your physician evaluate your illness. All information is confidential and will not be released without your written permission.

List of Chronic Medical Illnesses or Problems

Have you ever had any of the following?			Have you ever had any of the following?		
	Yes	No		Yes	No
Prior Cancers - Type	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Cystitis or Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis (Men Only)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Have you had more than 2 episodes within 3 years:	<input type="checkbox"/>	<input type="checkbox"/>
BPH/Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease or Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Neurologic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Severe Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
TURP (Men Only)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, date of TURP _____		
Diverticular Disease	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, year of onset _____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, date of onset _____		
Chronic	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers of Stomach or Small Intestine	<input type="checkbox"/>	<input type="checkbox"/>

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Bronchitis/Emphysema					
Other Collagen Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots or Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other Urological Operations/Procedures	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please list in "surgeries" section below		
Hernia	<input type="checkbox"/>	<input type="checkbox"/>			
Which type?	<input type="checkbox"/> Inguinal		<input type="checkbox"/> None		<input type="checkbox"/> Hiatal

Medical History:

Yes No

Do you have a pacemaker or internal defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hip surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries, Procedures & Hospitalizations:

Type of Procedures or Hospitalizations	Where	Year

Important: Prior Cancer Treatments

Have you ever had any radiation (ex: seeds, cobalt, external radiation, radioisotopes including treatment for birthmarks, acne, cancer etc.?)

Yes No

If Yes, where (name of institution) was this performed, what for, and when?

Have you ever received Chemotherapy? Yes No

If Yes, what drugs and when?

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Have you received hormone therapy for cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, what drugs (i.e. Tamoxifen, Femara, Lupron, Casodex)?	
Hormone Therapy Name/Dose/Frequency	Date

For Women: (Gynecological History):

Menarche (First Menstrual Period) (Age):	Last Menstrual Period (Date):	
How many days does the period usually last	Age at menopause:	
Are you or could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age at first pregnancy?
Pregnancies (Number):	Miscarriage (Number):	Deliveries (Number):
Are you currently on Birth Control:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?
Did you ever take hormones (i.e., estrogen, birth control pills, androgens, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?

Medications:

List the medications you are presently taking, including OTC, Vitamins and Supplements:			
Prescription	Dosage	Frequency	For What?

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Allergies (Drug, Food, Iodine etc.):

Do you have any allergies? Yes No

If Yes, what are you allergic to and what type of reaction do you get?

Family History:

Relation	Age	Medical Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Comments:			

Social History:

Marital Status: Single Married Divorced/Separated Widowed Partnered

Spouse/Partner's Name: _____

Patient Occupation: _____

Work Situation: Full Time Part Time Medical Leave Disability Retired

Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes, or other carcinogens? Yes No

What: _____ For how many years? _____

Living Situation: House Apartment Mobile Home Who lives with you? _____

Transportation: Able to drive self Driver required

Do you follow any special diet? Regular Vegan/Vegetarian Renal Diabetic

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

REVIEW OF SYSTEMS

Please check any of the following symptoms that you are currently experiencing. If you do not have any of the listed symptoms in each section, please check [NONE] at the top of each section.

GENERAL/CONSTITUTIONAL:		If none of the following apply, check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweat
<input type="checkbox"/> Chills/Rigors/Tremors	<input type="checkbox"/> Problems Sleeping	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Weight Loss/Change: If yes, #lbs pounds over _____ for _____ months. Intentional? <input type="checkbox"/> Yes <input type="checkbox"/> No			
EYES:		If none of the following apply check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Increased Tearing	<input type="checkbox"/> Night Blindness
<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/> Visual Difficulties		
HEAD & NECK (ENTM):		If none of the following apply, check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Painful Swallowing
<input type="checkbox"/> Difficulty Hearing	<input type="checkbox"/> Mouth Dryness	<input type="checkbox"/> Bleeding in Mouth	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Mouth Sores	<input type="checkbox"/> Taste Alterations
<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Masses or Lumps		
SKIN:		If none of the following apply check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Blisters	<input type="checkbox"/> Bruising	<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Facial Burning	<input type="checkbox"/> Nail Changes	<input type="checkbox"/> Sensitivity to Sun	<input type="checkbox"/> Itching
<input type="checkbox"/> Rash	<input type="checkbox"/> Hives		
BREAST:		If none of the following apply check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Lump or Mass in Breast	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Nipple Inversion	<input type="checkbox"/> Pain in Breast
CARDIOVASCULAR:		If none of the following apply check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Edema/Swelling of Feet
<input type="checkbox"/> Sleep Sitting or Propped Up	<input type="checkbox"/> Palpitations		
RESPIRATORY:		If none of the following apply check: NONE <input type="checkbox"/>	
<input type="checkbox"/> Cough	<input type="checkbox"/> Cough Up Blood: How Long? _____	<input type="checkbox"/> Cough Up Sputum: Color?	
<input type="checkbox"/> Hiccoughs	<input type="checkbox"/> Difficult/Painful Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chest Wall Pain
Are you able to lie flat? <input type="checkbox"/> Yes <input type="checkbox"/> No		Oxygen Use	_____ L/min
Shortness of Breath on Exertion: <input type="checkbox"/> Yes <input type="checkbox"/> No			
What Activity causes or makes it worse? _____			

Patient Reported History

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

GASTROINTESTINAL:	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Abdominal Pain Cramping	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heartburn/Dyspepsia	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Symptomatic Hemorrhoids	<input type="checkbox"/> Nausea
<input type="checkbox"/> Bloody Stools/ Black Stools/GI Bleeding	<input type="checkbox"/> Satiety/Feel Full Quickly	<input type="checkbox"/> Vomiting	
GENITOURINARY:	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Pain or Burning on Urination	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Impotence
<input type="checkbox"/> Leakage or Loss of Bladder Control	<input type="checkbox"/> Get up at Night to Urinate: How Often? _____		
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Urgent Urination	<input type="checkbox"/> Change in Sexual Function	
MUSCULO-SKELETAL:	If none of the following apply check: NONE		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bone Pain	<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Weak Muscles
<input type="checkbox"/> Decreased Range of Motion			
NEUROLOGIC:	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gait Changes	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Numbness or Tingling: Where? _____	
Weakness in Part of Body: Where? _____		<input type="checkbox"/> Seizure	<input type="checkbox"/> Sensory Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Claustrophobia		
PSYCHIATRIC:	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Delusions	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Change in Personality			
If you check yes to any of these, how long have you had these problems? _____			
Have you seen other doctors for these problems? _____			
ENDOCRINE:	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Thyroid Disease	
HEMATOLOGICAL/LLYMPHATIC:	If none of the following apply, check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Excessive Bruising	<input type="checkbox"/> Irregularities	<input type="checkbox"/> Swollen Lymph Glands	
OB-GYN (For Women):	If none of the following apply check: NONE <input type="checkbox"/>		
<input type="checkbox"/> Unusual Vaginal Bleeding	<input type="checkbox"/> Unusual Vaginal Discharge	<input type="checkbox"/> Painful/Difficult Intercourse	
<input type="checkbox"/> Vaginal Spotting			

Registration Form

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Date: _____

Patient RT#: _____

First Name MI Last Name Date of Birth Age

Address Apt# City State Zip County of Residence

Home Phone Work Phone Cell Phone Secure e-mail

Check your preferred method of contact Secure e-mail Mail (to address above)

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

Social Security # (optional) _____ Sex: Male Female

Preferred Language: _____ Marital Status: Single Married Widow Divorced

Ethnicity: Hispanic/Latino Not Hispanic/Latino Do not want to provide Do not know

Race: American Indian or Alaska Native Asian Black or African American White
 Native Hawaiian or Pacific Islander

Employed: Yes No Retired No Yes ___ Disabled: No Yes _____.
Date Date

Employer: _____ Occupation: _____

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice Yes No

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital SNF, Convalescent Home or Hospice.

Name of Facility _____ Phone _____

Address _____ City _____ State _____ Zip _____

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

INSURANCE INFORMATION

Primary Insurance	Medical Group (HMO)	ID#	Group#
Name/Relation of Policy Holder	Social Security # of Policyholder	Date of Birth of Policyholder	

Secondary Insurance	Medical Group (HMO)	ID#	Group#
Name/Relation of Policy Holder	Social Security# of Policyholder	Date of Birth of Policyholder	

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

EMERGENCY CONTACT

Name	Phone	Relationship
------	-------	--------------

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number _____

Patient/Guardian Signature _____ **Date** _____

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Assignment of Benefits

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to

Radiotherapy Clinics of Georgia (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill *if* the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature _____ Date: _____

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have received the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature _____ Date: _____

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Advanced Care Planning

We are working to increase awareness of "Advanced Care Planning (ACP)" with all of our patients. Do you currently have a Living Will or a Power of Attorney for Healthcare Form?

Yes No
Patient Declined

*If you answered "Yes," please be sure to provide a copy of your ACP documents and/or the full name of the Surrogate Decision Maker below, along with these completed forms.

Do you have a Healthcare Surrogate Decision Maker?

Yes No
Patient Declined

*If you answered "Yes," please provide the full name and contact number of the Healthcare Surrogate Decision Maker, as well as the relationship to the patient below, along with these completed forms.

Healthcare Surrogate Decision Maker: _____ Date: _____
(Please Print Full Name)

Healthcare Surrogate Decision Maker Contact Number: _____

Relationship to Patient: _____

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Authorization for Release of PHI to Care Givers
(For individuals directly involved in the patient's care or payment for care)

I, _____, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed) _____.
Relationship _____.
Date of Birth ____ / ____ / ____ Phone Number _____.

Name (Printed) _____.
Relationship _____.
Date of Birth ____ / ____ / ____ Phone Number _____.

Name (Printed) _____.
Relationship _____.
Date of Birth ____ / ____ / ____ Phone Number _____.

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient _____

Name (Printed) _____ Date _____

Personal Representative

I, _____, attest that I can act on behalf of _____ (patient) for purposes of treatment authorization and or Use and Disclosure of the patients PHI through rights afforded to me by the state. I will provide all legal documentation required to support the above statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature _____

Name (Printed) _____ Date _____

Patient Name: _____

Form Completion Date: _____

Medical Record # _____

Physician List

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at the time of your visit, please call us when you get home. This information is very important so that we can inform your physicians of your progress.

Primary Physician:

Address:

Phone:

Referring Physician:

Address:

Phone:

Medical Oncologist:

Address:

Phone:

Surgeon:

Address:

Phone:

OB/GYN:

Address:

Phone:

Other Physician:

Address:

Phone: