

## 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"/>

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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?

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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?

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**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
<b>Father</b>			
<b>Mother</b>			
<b>Brothers</b>			
<b>Sisters</b>			
<b>Children</b>			
<b>Comments:</b>			

**Social History:**

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered				
Spouse/Partner's Name: _____				
Patient Occupation: _____				
Work Situation: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Medical Leave <input type="checkbox"/> Disability <input type="checkbox"/> Retired				
Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes, or other carcinogens? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What: _____			For how many years? _____	
Living Situation: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home		Who lives with you? _____		
Transportation: <input type="checkbox"/> Able to drive self <input type="checkbox"/> Driver required				
Do you follow any special diet? <input type="checkbox"/> Regular		<input type="checkbox"/> Vegan/Vegetarian		<input type="checkbox"/> Renal <input type="checkbox"/> Diabetic

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### 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.**

<b>GENERAL/CONSTITUTIONAL:</b>		<b>If none of the following apply, check: NONE</b> <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			
<b>EYES:</b>		<b>If none of the following apply check: NONE</b> <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		
<b>HEAD &amp; NECK (ENTM):</b>		<b>If none of the following apply, check: NONE</b> <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		
<b>SKIN:</b>		<b>If none of the following apply check: NONE</b> <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		
<b>BREAST:</b>		<b>If none of the following apply check: NONE</b> <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
<b>CARDIOVASCULAR:</b>		<b>If none of the following apply check: NONE</b> <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		
<b>RESPIRATORY:</b>		<b>If none of the following apply check: NONE</b> <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? _____			

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<b>GASTROINTESTINAL:</b>	<b>If none of the following apply check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Abdominal Pain Cramping	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Heartburn/Dyspepsia	<input type="checkbox"/> Vomiting Blood
<input type="checkbox"/> Bloody Stools/ Black Stools/GI Bleeding	<input type="checkbox"/> Satiety/Feel Full Quickly
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Symptomatic Hemorrhoids	<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting	
<b>GENITOURINARY:</b>	<b>If none of the following apply check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Pain or Burning on Urination	<input type="checkbox"/> Frequent Urination
<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	<input type="checkbox"/> Impotence
<b>MUSCULO-SKELETAL:</b>	<b>If none of the following apply check: NONE</b>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bone Pain
<input type="checkbox"/> Decreased Range of Motion	<input type="checkbox"/> Painful Joints
	<input type="checkbox"/> Weak Muscles
<b>NEUROLOGIC:</b>	<b>If none of the following apply check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Gait Changes	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Numbness or Tingling: Where? _____	
Weakness in Part of Body: Where? _____	<input type="checkbox"/> Seizure
<input type="checkbox"/> Stroke	<input type="checkbox"/> Sensory Problems
<input type="checkbox"/> Claustrophobia	
<b>PSYCHIATRIC:</b>	<b>If none of the following apply check: NONE</b> <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? _____	
<b>ENDOCRINE:</b>	<b>If none of the following apply check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Thyroid Disease	
<b>HEMATOLOGICAL/LLYMPHATIC:</b>	<b>If none of the following apply, check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Excessive Bruising	<input type="checkbox"/> Irregularities
<input type="checkbox"/> Swollen Lymph Glands	
<b>OB-GYN (For Women):</b>	<b>If none of the following apply check: NONE</b> <input type="checkbox"/>
<input type="checkbox"/> Unusual Vaginal Bleeding	<input type="checkbox"/> Unusual Vaginal Discharge
<input type="checkbox"/> Vaginal Spotting	<input type="checkbox"/> Painful/Difficult Intercourse

# 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 \_\_\_\_\_

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**INSURANCE INFORMATION**

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

<b>Secondary Insurance</b>	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
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**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**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: \_\_\_\_\_

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### **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: \_\_\_\_\_

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### 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:**