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	☐	☐	Kidney Failure	☐	☐
Angina	☐	☐	Kidney Stones	☐	☐
Heart Attacks	☐	☐	Cystitis or Bladder Infections	☐	☐
Heart Failure	☐	☐	Prostatitis (Men Only)	☐	☐
Heart Murmur	☐	☐	Arthritis	☐	☐
Irregular Heartbeat	☐	☐	Have you had more than 2 episodes within 3 years:	☐	☐
BPH/Enlarged Prostate	☐	☐	Elevated Cholesterol	☐	☐
Lupus	☐	☐	Stroke or Paralysis	☐	☐
Scleroderma	☐	☐	Asthma	☐	☐
Anemia	☐	☐	Tuberculosis	☐	☐
HIV or AIDS	☐	☐	Seizures or Epilepsy	☐	☐
Diabetes	☐	☐	Irritable Bowel Syndrome	☐	☐
Hemorrhoids	☐	☐	Thyroid Disease or Goiter	☐	☐
Rectal Bleeding	☐	☐	Glaucoma/Cataracts	☐	☐
Gallbladder Disease	☐	☐	Parkinson's Disease	☐	☐
Hepatitis or Liver Disease	☐	☐	Multiple Sclerosis	☐	☐
Pancreatitis	☐	☐	Other Neurologic Problems	☐	☐
Crohn's Disease	☐	☐	Skin Condition(s)	☐	☐
Colitis	☐	☐	Severe Anxiety	☐	☐
TURP (Men Only)	☐	☐	If Yes, date of TURP _____		
Diverticular Disease	☐	☐	If Yes, year of onset _____		
High Blood Pressure	☐	☐	If Yes, date of onset _____		
Chronic	☐	☐	Ulcers of Stomach or Small Intestine	☐	☐

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

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

Medical History:

	Yes	No
Do you have a pacemaker or internal defibrillator?	☐	☐
Have you ever had hip surgery?	☐	☐

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? ☐ Yes ☐ 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?	☐ Yes ☐ No	Age at first pregnancy?
Pregnancies (Number):	Miscarriage (Number):	Deliveries (Number):
Are you currently on Birth Control:	☐ Yes ☐ No	If yes, what?
Did you ever take hormones (i.e., estrogen, birth control pills, androgens, etc.)?	☐ Yes ☐ 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 <u>that you are currently experiencing.</u> 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** ☐

☐ Loss of Appetite ☐ Fatigue ☐ Fever ☐ Night Sweat
☐ Chills/Rigors/Tremors ☐ Problems Sleeping ☐ Dizziness

☐ Weight Loss/Change: If yes, #lbs pounds over _____ for _____ months. Intentional? ☐ Yes ☐ No

EYES: **If none of the following apply check: NONE** ☐

☐ Blurred Vision ☐ Double Vision ☐ Increased Tearing ☐ Night Blindness
☐ Sensitivity to Light ☐ Visual Difficulties

HEAD & NECK (ENTM): **If none of the following apply, check: NONE** ☐

☐ Difficulty Swallowing ☐ Ear pain ☐ Nose Bleeds ☐ Painful Swallowing
☐ Difficulty Hearing ☐ Mouth Dryness ☐ Bleeding in Mouth ☐ Ear Infections
☐ Sinusitis ☐ Sputum Production ☐ Mouth Sores ☐ Taste Alterations
☐ Ringing in the Ears ☐ Masses or Lumps

SKIN: **If none of the following apply check: NONE** ☐

☐ Hair Loss ☐ Blisters ☐ Bruising ☐ Dry Skin
☐ Facial Burning ☐ Nail Changes ☐ Sensitivity to Sun ☐ Itching
☐ Rash ☐ Hives

BREAST: **If none of the following apply check: NONE** ☐

☐ Lump or Mass in Breast ☐ Nipple Discharge ☐ Nipple Inversion ☐ Pain in Breast

CARDIOVASCULAR: **If none of the following apply check: NONE** ☐

☐ Irregular Heartbeat ☐ Chest Pain ☐ Shortness of Breath ☐ Edema/Swelling of Feet
☐ Sleep Sitting or Propped Up ☐ Palpitations

RESPIRATORY: If **none of the following apply check: NONE** ☐

☐ Cough ☐ Cough Up Blood: How Long?_____ ☐ Cough Up Sputum: Color?
☐ Hiccoughs ☐ Difficult/Painful Breathing ☐ Wheezing ☐ Chest Wall Pain

Are you able to lie flat? ☐ Yes ☐ No Oxygen Use _____L/min

Shortness of Breath on Exertion: ☐ Yes ☐ 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** ☐

☐ Abdominal Pain Cramping ☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea

☐ Heartburn/Dyspepsia ☐ Vomiting Blood ☐ Symptomatic Hemorrhoids ☐ Nausea

☐ Bloody Stools/ Black Stools/GI Bleeding ☐ Satiety/Feel Full Quickly ☐ Vomiting

GENITOURINARY: **If none of the following apply check: NONE** ☐

☐ Pain or Burning on Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Impotence

☐ Leakage or Loss of Bladder Control ☐ Get up at Night to Urinate: How Often? _____

☐ Kidney Stones ☐ Urgent Urination ☐ Change in Sexual Function

MUSCULO-SKELETAL: **If none of the following apply check: NONE**

☐ Arthritis ☐ Bone Pain ☐ Painful Joints ☐ Weak Muscles

☐ Decreased Range of Motion

NEUROLOGIC: **If none of the following apply check: NONE** ☐

☐ Disorientation ☐ Dizziness ☐ Gait Changes ☐ Frequent Headaches

☐ Difficulty Sleeping ☐ Memory Loss ☐ Numbness or Tingling: Where? _____

Weakness in Part of Body: Where? _____ ☐ Seizure ☐ Sensory Problems

☐ Stroke ☐ Claustrophobia

PSYCHIATRIC: **If none of the following apply check: NONE** ☐

☐ Delusions ☐ Hallucinations ☐ Depression ☐ Mood Swings

☐ 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** ☐

☐ Diabetes ☐ Hot Flashes ☐ Thyroid Disease

HEMATOLOGICAL/LLYMPHATIC: **If none of the following apply, check: NONE** ☐

☐ Excessive Bruising ☐ Irregularities ☐ Swollen Lymph Glands

OB-GYN (For Women): **If none of the following apply check: NONE** ☐

☐ Unusual Vaginal Bleeding ☐ Unusual Vaginal Discharge ☐ Painful/Difficult Intercourse

☐ Vaginal Spotting

Male Urinary and Sexual Health Questionnaire

Your Name: _____

Date:_____

Please answer the following questions about your urinary symptoms and potency for the period of time over the last 30 days. Please circle the appropriate answer.

Urinary Symptoms

Key:

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

Please circle the answer that best describes your response to each of the following questions:

1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?

0	1	2	3	4	5

2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?

0	1	2	3	4	5

3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?

0	1	2	3	4	5

4. Urgency Over the past month, how often have you found it difficult to postpone urination?

0	1	2	3	4	5

5. Weak stream Over the past month, how often have you had a weak urinary stream?

0	1	2	3	4	5

6. Straining Over the past month, how often have you had to push or strain to begin urination?

0	1	2	3	4	5

7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

0 times	1 time	2 times	3 times	4 times	5 + times

Score _____ (Office Use only)

List medication used to improve urination

Drug: _____

Dosage: _____

Potency

Each question has several possible responses. Please circle the number of the response that best describes your own situation. Make sure that you select only one response for each question.

Over the past six months:

1. How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost Always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not Attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not Attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory to you?

Did not Attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

Score _____ (Office Use Only)

List medication used to help with erections

Drug: _____

Dosage: _____

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 Assig nment 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 #_____

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: _____