MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA

HELEN F GRAHAM CANCER CTR WEST - 4701 OGLETOWN-STANTON RD - SUITE 3400 - NEWARK, DE 19713-2055

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Thank you for selecting our practice for your care. We hope to make your visit as comfortable as possible.

NOTE: If you have ANY questions prior to your new patient appointment, please contact one of our New Patient Coordinators at (302) 366-1200, ext. 290.

Helpful Information

FORMS (New Patient)

- Complete the enclosed forms and bring them with you to your appointment. Fill out both sides, including insurance information, and sign all places where indicated. We must have the full names and contact information for all physicians involved in your care.
- Please make note of the following:
    - Bring all insurance cards, including any prescription cards
    - Bring a list of ALL medications you take, including the strength & the times you take a day, as well as *any vitamins, over-the-counter medications and any complementary/alternative treatments you are using*; we will be verifying your medications at every visit; please include name and contact information about your pharmacy

INSURANCE

- Please call our Billing Department at (302) 451-1210 if you have changed your insurance coverage since your appointment was made—we will need to verify if we participate with your new insurance.
- ATTENTION MEDICARE-ELIGIBLE PATIENTS: There are some Medicare-replacement plans that we do not participate with. Please call our Billing Department at (302) 451-1210 to check that we accept your plan.

IDENTIFICATION

- For purposes of preventing identity theft, it is necessary that you bring a photo ID and confirmation of current address if the address as shown on your ID is incorrect, or if it is a PO Box.
- For those of you on Medicare or Medicaid, we will be using the name as it appears on your card on your chart
- We take pictures of our patients at their first visit to help the physician and staff to remember and identify you.

MANAGED CARE

- If you have insurance that requires a referral, please contact your primary care physician prior to your appointment to obtain a referral.
- For questions about referrals and precertification, you can call our Precertification Department directly at (302) 451-1209.

REGISTRATION

(Please arrive at least 20 minutes early for your appointment with your completed forms to register)

- When we receive your paperwork at our front desk, we will complete your registration into our computer system.
- As a private practice, our computer system and Christiana Care's system are separate; if you have any changes in insurance, address, etc., please notify our front desk and also update Christiana Care's system if you receive any services from them (like lab and imaging).

PAYMENTS/BILLING

- Payment is expected at the time of service. See the enclosed *Financial Policy* for more details.
- For billing questions, you can call our Billing Department directly at (302) 451-1210.
- If you have questions about lab or imaging bills, or any other Christiana Care-related service, contact them directly by calling the number located on your bill.

OFFICE HOURS

- Our office is open Monday-Friday, 8:30 AM to 5 PM, except for the major holidays; in the case of inclement weather, please call ahead to our main number.
- Our physicians are available for emergencies after hours and weekends by calling our answering service at our main number (302) 366-1200.

PRESCRIPTION REFILLS

- Medication refills can be requested by calling our main number (302) 366-1200 and listening for the prompts; please call for refills before you run out of medication and allow 24-48 hours for the prescription request to be processed.
- Medication refills are only handled during regular office hours and will not be refilled by the on-call physician after hours.

HOSPITAL COVERAGE (Christiana Hospital and Wilmington Hospital)

- The physicians of our group rotate hospital coverage; if admitted to Christiana Care or Wilmington Hospital, you will be seen by one of the physicians in our group.

OFFICE ACCESSIBILITY

- The building has automatic doors and our office has doors that can be opened mechanically by pushing a button; wheelchairs are located on the 1st floor of the building behind the reception desk.

CLINICAL OFFICE STAFF

- Our highly qualified Nurse Practitioners see patients along with our physicians in the office and at the hospital.
- For medical questions during office hours, speak to the RN who covers your physician; your physician's nurse can be reached by calling our main number (302) 366-1200 and listening for the prompts.

FORM PREPARATION (for example disability forms, FMLA forms, etc)

- We ask that you allow 2 weeks for our nurse to complete form preparation.
- There is a fee associated with form preparation.

IF PROBLEMS ARISE

- If you are unable to resolve a problem with one of our staff, please contact our Office Manager or Nurse Manager by calling our main number at (302) 366-1200.

Our office is in the new addition of the Helen F. Graham Cancer Center. Enter at the West entrance (go past the first entrance around to the right into the large parking area) and take the elevators to the 3rd floor, Suite 3400.

MOHC MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA | The US Oncology Network

Name you like to be called: Last 4 of SS#

❒ Male ❒ Female ❒ Transgender ❒ Other:

Gender Expression (Sex) _____ DOB _____/_____/_____ Email:_____

Pharmacy Name Phone Number: _____/ ( )_____-_____

Relationship Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Long-term Commitment

Emergency Contact:_____Relationship:_____Phone#_____

Emergency Contact:_____Relationship:_____Phone#_____

Partner's Name: _____ Phone #: _____

United States Citizenship: ❒ Citizen ❒ Permanent Resident ❒ VISA ❒ Other: _____

Please list your mailing address here *if it is not the same as where you live*:

Address:

Do you have an Advance Directive (living will)? ❒ Yes ❒ No * Please provide copies if you

Do you have a Power of Attorney for medical decisions? ❒ Yes ❒ No have either of these

Primary Care Physician_____ Phone #: _____

Whom may we thank for referring you to MOHC?

*MOHC has limited retail pharmacy services available for use with obtaining medications prescribed by MOHC providers. Our pharmacist is available for education about medications and to help determine your insurance coverage and copayment for the medication. *However, you are always able to use your pharmacy of your choice.*

1. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to MOHC. I also authorize agents of any hospital, treatment center or previous physician to furnish MOHC copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research, and quality assurance reviews within MOHC.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to MOHC. This assignment covers all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I
will endorse such payments to MOHC.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

Privacy Practice

MOHC, PA. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights regarding your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices

☐ **I confirm that I have had the opportunity to read and review, the privacy policy provided to me by MOHC.**

Who may we speak with or release information regarding your care?

_____ _____

Primary Spokesperson **Relationship**

_____ _____

Additional Spokesperson **Relationship**

Patient or Representative Signature: _____ **Date:** _____

MOHC
MEDICAL ONCOLOGY
HEMATOLOGY CONSULTANTS, PA

The US Oncology Network

PATIENT RIGHTS AND RESPONSIBILITIES

1. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks, and an explanation of consequences if treatment is not pursued.
2. An explanation of all services provided by MOHC, the days and hours of service and provisions for possible emergency care, including telephone numbers.
3. Participate in development of a plan of treatment.
4. Make known Advance Directives or a Living Will if I wish.
5. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previous given consent for further treatment.
6. Disclosure of any teaching programs, research, or experimental programs in which the facility is participating.
7. Full financial explanation and payment schedule prior to beginning treatment.
8. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex, or age.
9. Be treated with courtesy, dignity, and respect of my personal privacy by all employees of MOHC
10. Complain or file grievances with representatives of MOHC without fear of retaliation or discrimination.
11. Confidential treatment of my condition, medical record, and financial information.
12. Access to my personal records and obtain copies upon written request.

As a PATIENT, I have the RESPONSIBILITY to:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history, and related items.
2. Assist in maintaining a safe, peaceful, and efficient ambulatory environment.
3. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed co-pay during my office visit.
4. Contact the office when unable to keep a scheduled appointment.
5. Cooperate in the planned care and treatment developed for me.
6. Request more detailed explanations for any aspect of service I don't understand.
7. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.
8. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the office staff.

Medical Oncology Hematology Consultants, PA

NOTICE OF PRIVACY PRACTICES

Effective Date: **September 4, 2019**

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.

About Us

In this Notice, we use terms like “we,” “us,” “our” or "Practice" to refer to **Medical Oncology Hematology Consultants, PA,** its physicians, employees, staff, and other personnel. All the sites and locations of **Medical Oncology Hematology Consultants, PA** follow the terms of this Notice and may share health information with each other for treatment, payment, or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company, or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used during treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your physical location within the Practice, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery 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.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement.
- About a death we suspect may have resulted from criminal conduct.
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability.
- To report births or deaths.
- To report child abuse or neglect.
- Activities related to the quality, safety, or effectiveness of FDA-regulated products.
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to 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.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing your health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have acted in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713**. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.**
We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** Your request must state a time which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** You may also obtain a paper copy of this Notice at our website, www.mohcde.com

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice at **the front desk in the waiting room**. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www.mohcde.com

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Questions

If you have questions about this Notice, please contact **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713**

Medical Oncology Hematology Consultants, PA

Patient Financial Policy

We are pleased that you have chosen our practice as the place to receive your healthcare. We will always strive to give you the best of care. To maintain our service level, it is necessary for us to have the following policies:

- Payment of all copays, coinsurance, and other patient financial responsibilities is required at the time of each office service.
- If you have an insurance that requires a copay, unless we are notified otherwise by your insurance, it will apply to every visit you make to our practice, including those visits when you do not see a physician directly—such as for an injection or port flush.
- Before receiving chemotherapy in our office, you will be meeting with one of our Patient Benefits Representatives to review the approximate financial responsibility you may have. Payment must be made before treatment can be administered. If you are unable to make full payment for treatment in our office, we will review other options with you.
- If your insurance requires referrals, you are expected to be responsible for obtaining them unless we tell you otherwise. Your visit will need to be rescheduled if there is not a proper referral in place at the time of your visit.
- You must notify our office immediately of any changes in your insurance. You will be held liable for your full balance with our practice if you have not properly informed us of any changes, as we may not be able to bill your insurance because of timely filing rules.
- If you are on traditional Medicare and switch to a Medicare replacement (or switch from Medicare replacement plan to another), you must contact our billing office at 302-366-1200 to confirm that we are participating with your plan.
- If you are uninsured, we may be able to make payment arrangements for our physician visits after thoroughly reviewing your financial situation. Any treatment costs will be reviewed with you in advance.
- Our office accepts VISA, MasterCard, Discover, American Express, debit cards, cash, and personal checks.
- There is a returned check fee of $25.00.
- It is your responsibility to promptly bring in any payments your insurance company may have sent to you instead of to us, along with the Explanation of Benefits.

Insurance policies are ultimately a contract between yourself and the insurance company. It will be your responsibility to know how your plan works, what the specifics are, including, but not limited to copays, referrals, deductibles, coinsurance, limitations of service, and non –covered services.

These policies apply only to bills from our private practice, Medical Oncology Hematology Consultants. Bills for other services such as lab work and radiology are separate from our practice. Lab work done in the lab located next to our office is provided by Christiana Care.

Please indicate that you have read, understand, and have received a copy of this policy by signing below.

Name (print)_____ Date _____

Signature_____

Signature of witness _____

MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA

NEW PATIENT MEDICAL HISTORY FORM

PATIENT NAME_____ **DATE**_____

Please list any drug/medication ALLERGIES: _____

Please name any other physicians you are currently seeing (and list their specialties):

Referring Physician_____ **Primary Physician**_____

Other Physicians _____

Your physician or nurse practitioner will review this information with you. You should also be prepared for a physical exam.

MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING *(Please check all that apply)*?

	Yes,	No		Yes	No		Yes	No
Pneumonia	☐	☐	Diabetes	☐	☐	Anemia	☐	☐
High cholesterol	☐	☐	Thyroid disease	☐	☐	Blood clots	☐	☐
Heart attack	☐	☐	Hepatitis	☐	☐	Arthritis	☐	☐
Stroke/TIA	☐	☐	Tuberculosis	☐	☐	Osteopenia/Osteoporosis	☐	☐
Heart Disease	☐	☐	Kidney disease	☐	☐	Eye Problems	☐	☐
Stomach ulcers	☐	☐	High Blood Pressure	☐	☐	Seizures	☐	☐
Cancers (list below) ☐		☐	COPD	☐	☐	Depression/Anxiety	☐	☐

_____

HAVE YOU EVER HAD SURGERY FOR ANY OF THE FOLLOWING?

	Yes,	No		Yes	No
Appendix	☐	☐	Hemorrhoids	☐	☐
Tonsils	☐	☐	Hernia	☐	☐
Hysterectomy	☐	☐	Heart	☐	☐
Gallbladder	☐	☐	Teeth	☐	☐
Cataracts	☐	☐	Vascular (veins/arteries)	☐	☐

Any other surgeries (please list) _____

Any hospitalizations (other than surgery or childbirth) _____

Women: # of pregnancies _____ **# of Deliveries** _____ **Complications Y N**

First day of last menses: _____ **Heavy Menstrual Flow Y N Age at menopause**_____

Contraceptives: _____ **Hormone Replacement Therapy Y N**

FAMILY HISTORY:

Mother's age now_____ or age when passed away_____
Her medical problems_____

Father's age now_____ or age when passed away_____
His medical problems
_____
#_____brothers/ #_____sisters
any medical problems/cancers_____

Do you have relatives with any of the following (please circle)?
Heart Attack Diabetes Heart DiseaseStroke Blood Disorders High Blood Pressure Asthma Tuberculosis
Cancer (please list types) _____

PERSONAL HISTORY:

CANCER SCREENING:

Have you had a:

Mammogram	Y	N	please give approximate date_____
Gynecologic exam/Pap smear	Y	N	please give approximate date_____
Colonoscopy	Y	N	please give approximate date_____
Prostate exam/PSA	Y	N	please give approximate date_____

Do you:
Smoke Y N-if so, Packs per day_____ or quit smoking_____years ago
Consume Alcohol Y N-if so, # drinks per week_____ or were you ever a heavy drinker Y N
Quit drinking____years ago
Have any religious beliefs/restrictions that affect your medical care? Y N (please list) _____
Have you ever had:

Asbestos Exposure Y N Other Toxin Exposure Y N (please list) _____

Please List:

Present Occupation_____Previous Occupation_____

Marital Status_____With whom do you live_____

Patient Name: _____

REVIEW OF SYSTEMS:

Have you experienced any of the symptoms?

	Yes	No
Frequent headaches	☐	☐
Change in vision	☐	☐
Sinus problems	☐	☐
Weight loss (# of lbs.____)	☐	☐
Sleep problems	☐	☐
Nervousness	☐	☐
Appetite problems	☐	☐
Painful/stiff neck	☐	☐
Coughing blood	☐	☐
Acid indigestion/heartburn	☐	☐
Pain in abdomen	☐	☐
Frequent Urination	☐	☐
Slow urine stream	☐	☐
Arthritis	☐	☐
Brief weakness of hand or leg	☐	☐
Anemia	☐	☐
Easy bruising	☐	☐
Weight gain	☐	☐
Heavy night sweats	☐	☐
Fevers	☐	☐
Sore throats	☐	☐
Trouble swallowing	☐	☐
Shortness of breath	☐	☐
Cough	☐	☐
Chest pain	☐	☐
Palpitations/ Rapid heartbeat	☐	☐
Nausea/vomiting	☐	☐
Diarrhea/constipation	☐	☐
Blood in stool	☐	☐
Back pain	☐	☐
Kidney infections	☐	☐
Blood in urine	☐	☐
Waking up to urinate more than once	☐	☐
Pain/stiff joints	☐	☐
Stroke/TI's	☐	☐
Vision loss	☐	☐
Bleeding easily	☐	☐
Moles changing color/size	☐	☐
Any skin rashes	☐	☐
Irregular menstrual cycle	☐	☐

Other_____

_____

_____

Medical Oncology Hematology Consultants, PA
Patients Medication Record

Please list all medications—prescription and non-prescription--***EACH TIME*** you come to see the doctor. *If you are not taking any medications, please write "NONE".*

DO NOT include any of your cancer treatment drugs.

Name_____ Date_____

NAME OF DRUG	DOSE	TIMES YOU TAKE A DAY