

Patient Reported History

Patient Name: _____

Medical Record #: _____

Form Completion Date: _____

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?	Yes	No	Have you ever had any of the following?	Yes	No
Prior Cancers – Type _____			Kidney Failure		
Angina			Kidney Stones		
Heart Attacks			Cystitis or Bladder Infections		
Heart Failure			Prostatitis (Men Only)		
Irregular Heart Beat			<i>Have you had more than 2 episodes within 3 years:</i>		
Heart Murmur			TURP (Men Only) <i>If Yes, date of TURP _____</i>		
Arthritis			Other Urological Operations/Procedures <i>If Yes, please list in “surgeries” section below</i>		
High Blood Pressure <i>If Yes, year of onset _____</i>			BPH/Enlarged Prostate		
Elevated Cholesterol			Lupus		
Stroke or Paralysis			Scleroderma		
Asthma			Other Collagen Vascular Disease		
Anemia			Blood Clots or Clotting Disorder		
Chronic Bronchitis/Emphysema			Tuberculosis		
Hernia <i>Which type? Inguinal</i> <i>None Hiatal</i>			HIV or AIDS		
Diverticular Disease			Diabetes <i>If Yes, year of onset _____</i>		
Hemorrhoids			Thyroid Disease or Goiter		
Rectal Bleeding			Glaucoma/Cataracts		
Ulcers of Stomach or Small Intestine			Seizures or Epilepsy		
Gallbladder Disease			Parkinson’s Disease		
Hepatitis or Liver Disease			Multiple Sclerosis		
Pancreatitis			Other Neurologic Problems		
Crohn’s Disease			Skin Condition(s)		
Colitis			Severe Anxiety		
Irritable Bowel Syndrome					

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Medical History:

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

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?	
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

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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: None Yes, if so 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?

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?

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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

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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.

<u>GENERAL/CONSTITUTIONAL:</u>		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, _____ pounds over _____ months. Intentional?		Yes	No
<u>EYES:</u>		If none of the following apply, check: NONE	
Blurred Vision	Double Vision	Increased Tearing	Night Blindness
Sensitivity to Light	Visual Difficulties		
<u>HEAD & NECK (ENTM):</u>		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		
<u>SKIN:</u>		If none of the following apply, check: NONE	
Hair Loss	Blisters	Bruising	Dry Skin
Facial Burning	Nail Changes	Sensitivity to Sun	Itching
Rash	Hives		
<u>BREAST:</u>		If none of the following apply, check: NONE	
Lump or Mass in Breast	Nipple Discharge	Nipple Inversion	Pain in Breast
<u>CARDIOVASCULAR:</u>		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		
<u>RESPIRATORY:</u>		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: What Activity causes or makes it worse? _____			

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<u>GASTROINTESTINAL:</u>		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
<u>GENITOURINARY:</u>		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	
<u>MUSCULO-SKELETAL:</u>		If none of the following apply, check: NONE	
Arthritis	Bone Pain	Painful Joints	Weak Muscles
Decreased Range of Motion			
<u>NEUROLOGIC:</u>		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		
<u>PSYCHIATRIC:</u>		If none of the following apply, check: NONE	
Delusions	Hallucinations	Depression	Change in Personality
Mood Swings			
If you check yes to any of these, how long have you had these problems? _____			
Have you seen other doctors for these problems? _____			
<u>ENDOCRINE:</u>		If none of the following apply, check: NONE	
Diabetes	Hot Flashes	Thyroid Disease	
<u>HEMATOLOGICAL/LYMPHATIC:</u>		If none of the following apply, check: NONE	
Excessive Bruising	Irregularities	Swollen Lymph Glands	
<u>OB-GYN (For Women):</u>		If none of the following apply, check: NONE	
Unusual Vaginal Bleeding	Unusual Vaginal Discharge	Painful/Difficult Intercourse	
Vaginal Spotting			

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 Mail (to address above) Check your preferred method of contact

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: M F

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 Native Hawaiian or Pacific Islander White

Employed: Yes No Retired: Yes No Disabled: Yes No

Employer: _____ Date 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

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

Physician List

Patient Name: _____ Date: _____

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:

Patient Referral Source Form

(Please return completed form to front desk)

Patient Name: _____

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(Office Only)

How did you hear about us? (check all that apply)

☐ Doctor: _____
Name

☐ Internet: _____
Blog, Website, Search

☐ Family/Friend: _____
Name (Optional)

☐ Georgia Billboard: _____
Location (Optional)

☐ Prior Patient: _____
Name (Optional)

☐ Radio/TV: _____
Station/Program

☐ Insurance Company: _____

☐ Patient Navigation Center: _____

☐ Magazine/Newspaper: _____
Name

☐ Other: _____
Health Fair, Event, etc.

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 _____

HI-500-004.001F1 - Authorization For Release of PHI to Care Givers

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: _____

Fundraising Communications Op-Out

By checking the box below I indicate that I do not want to receive any fundraising communications from my Provider.

☐ I do not want to receive any fundraising communications

Patient/Guardian Signature: _____ Date: _____