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	○	○	***Have you had more than 2 episodes within 3 years:***	○	○
Heart Murmur	○	○	TURP (Men Only) ***If Yes, date of TURP _____***	○	○
Arthritis	○	○	Other Urological Operations/Procedures ***If Yes, please list in "surgeries" section below***	○	○
High Blood Pressure ***If Yes, year of onset _____***	○	○	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 ***Which type?*** ○ ***Inguinal*** ○ ***None*** ○ ***Hiatal***	○	○	HIV or AIDS	○	○
Diverticular Disease	○	○	Diabetes ***If Yes, year of onset _____***	○	○
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	○	○			

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

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

Patient Name:_____ Medical Record #: _____

Form Completion 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: ○ 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?

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

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 Name:_____ Medical Record #: _____

Form Completion Date:_____

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** ☐

☐ Loss of Appetite ☐ Fatigue ☐ Fever ☐ Night Sweat

☐ Chills/Rigors/Tremors ☐ Problems Sleeping ☐ Dizziness

Weight Loss/Change: If yes, _____ pounds over _____ 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: What Activity causes or makes it worse?_____

Patient Name:_____ Medical Record #: _____

Form Completion Date:_____

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 ☐ 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? _____

ENDOCRINE: **If none of the following apply, check: NONE ☐**

☐ Diabetes ☐ Hot Flashes ☐ Thyroid Disease

HEMATOLOGICAL/LYMPHATIC: **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

American Urological Association (AUA) Questionnaire on Urinary Function

Name _____ **Date** _____

Implant # _____ ☐ PRE ☐ IMP ☐ XRT ☐ FU (Months after implant) _____

	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	YOUR SCORE
1 **Incomplete Emptying** Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2 **Frequency** Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3 **Intermittency** Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4 **Urgency** Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5 **Weak-stream** Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6 **Straining** Over the past month or so, 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?	None 0	1 time 1	2 times 2	3 times 3	4 times 4	5 times or more 5	
						Total your score here. Total Symptom Score = Sum of Questions 1 to 7 =	0

From the American Urological Association

(AUA) Symptom Index for BPH

SEXUAL HEALTH INVENTORY FOR MEN

PATIENT NAME: _____ **DATE OF EVALUATION:** _____

IMPLANT #:_____ ☐PRE ☐IMP ☐XRT ☐FU (Months after implant)_____

Please answer these six questions on erections using ONLY ONE of the possible answers under each question.

If you are ***not*** taking an **Erectile Dysfunction (ED)** drug, please put your answers in the "Natural" column labeled "**A**".

If you ***are*** taking an **Erectile Dysfunction (ED)** drug, please answer **BOTH** according to how your erections are **WITHOUT** the ED drug in column "**A**" (Natural) and **WITH** the ED drug in column "**B**".

Are you currently taking an ED Drug? ○ **No** ○ **Yes** ○ ***Viagra*** ○ ***Cialis*** ○ ***Levitra***

If yes, please choose dosage: Viagra: ○ **25** ○ **50** ◉ **100** **Cialis:** ○ **5** ○ **10** ○ **20** **Levitra:** ○ **5** ○ **10** ○ **20**

	"A" NATURAL (No ED)	**"B" WITH ED Drug**
Over the past 4 weeks:		
1. **How do you rate your confidence that you could get and keep an erection?** 1. Very low 3. Moderate 2. Low 4. High 5. Very High	**A.**_____	**B.**_____
2. **When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?** 0. No sexual activity 3. Sometimes (about half the time) 1. Almost never or never 4. Most times (much more than half) 2. A few times (much less than half the time) 5. Almost always or always	**A.**_____	**B.**_____
3. **During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?** 0. Did not attempt intercourse 3. Sometimes (about half the time) 1. Almost never or never 4. Most times (much more than half) 2. A few times (much less than half the time) 5. Almost always or always	**A.**_____	**B.**_____
4. **During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?** 0. Did not attempt intercourse 3. Difficult 1. Extremely difficult 4. Slightly Difficult 2. Very difficult 5. Not difficult	**A.**_____	**B.**_____
5. When you attempted sexual intercourse, how often was it satisfactory for you? 0. Did not attempt intercourse 3. Sometimes (about half the time) 1. Almost never or never 4. Most times (much more than half) 2. A few times (much less than half the time) 5. Almost always or always	**A.**_____	**B.**_____
SCORE: ADD Q1-Q5 Here:	**A.** 0	**B.** 0
6. How often do you have sexual intercourse with a partner? 1. I am capable of satisfactory sexual intercourse, but I have not attempted in the last six month or since last filling out this form. 3. Less than once a month 4. 1 to 3 times a month 5. 1 time a week 6. 2 to 3 times a week 2. Not at all, I cannot get an erection. 7. More than 4 times a week.	**A.**_____	**B.**_____

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

Marital Status: ◯ **Single** ◯ **Married** ◯ **Widow** ◯ **Divorced**

Preferred Language: _____

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** _____ Date **Disabled:** ◯ **Yes** ◯ **No** _____ 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

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:_____

Medical Record #: _____Form Completion Date: _____
(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: _____

Radiotherapy Clinics of Georgia
A Partner in The US Oncology Network

2349 Lawrenceville Highway
Decatur, GA 30033
T › 404-320-1550
F › 404-728-1081
www.rcog.com

PATHOLOGY SLIDES RELEASE

I authorize Radiotherapy Clinics of Georgia to obtain ALL my prostate pathology slides from:

Laboratory name: _____
Address: _____
_____
City/State/Zip: _____
Phone number: _____
Fax number: _____

for review by: Ameripath, Quest Diagnostics

I authorize the laboratory listed above, to accept a photocopy or facsimile of this document as my official consent to release my records.

X _____
Signature of Patient or Legal Guardian

_____ ____/____/____
Patient's printed name Patient's Date of Birth

Date _____

Please send ALL pathology slides to: Pathology Slides Coordinator, Radiotherapy Clinics of Georgia, 2349 Lawrenceville Highway, Decatur, GA 30033-3143

I understand that my insurance company will be billed by Ameripath, Quest Diagnostics for this pathology review and that any balance due after insurance will be my responsibility.

X _____
Signature of Patient or Legal Guardian

_____ ____/____/____
Patient's printed name Patient's Date of Birth

Date _____
