**Verdi cancer AND RESEARCH cENTER OF Texas**

REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | Today’s Date: | Primary Care Physician: | Referring Physician: |   **PATIENT INFORMATION**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Patient’s last name: | First name: | Middle name: |  | Marital status: | |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: | |  |  |  |  |  |  |   Street Address:   |  |  |  | | --- | --- | --- | | City: | State: | Zip Code: | | SSN.: | Home phone no.: | Cell phone no.: | | Birth City: | Birth State: | Birth Country: | | Occupation: | Employer: | Employer phone no.: |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Race: |  | Ethnicity: Hispanic / Non-Hispanic |  | Patient’s Email Address: |  | |  |  |  |  |  |  |   **INSURANCE INFORMATION**  (Please give your insurance card to the receptionist.)  Please indicate primary insurance:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | |  |  |  |  |  |   Patient’s relationship to subscriber:   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | |  |  |  |  |   **IN CASE OF EMERGENCY**  In the event of an emergency I authorize [Name of Practice] Center to share information about my medical condition with the following:   |  |  |  |  | | --- | --- | --- | --- | | Name of relative or friend: | Relationship to patient: | Home phone no.: | Cell phone no.: | |  |  |  |  |   The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] to release any information required to process my claims.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | Patient/Guardian signature |  | Date |  | |

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**PATIENT INFORMATION:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Last Name First Name M.I. (Maiden name if applicable) Date of Birth*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Street Address/PO Box Number City, State, Zip*

**RECORDS TO BE RELEASED FROM:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Name of Hospital/Clinic/Dr’s Office Phone Number*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Street Address/PO Box Number City, State, Zip*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize and request that the above named facility/clinic/office release any and all medical records, unless otherwise noted below, to Verdi Oncology Texas and/or its entities, Verdi Cancer and Research Center of Texas, for the purposes of my care. I understand that this authorization is subject to revocation by me, in writing, at any time except to the extent that action has already been taken based upon it.

**I do not wish to release the following medical records:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE**

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Patient*

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Authorized Representative Relationship*

**Verdi Cancer and Research Center of Texas**

**7777 Forest Ln, Suite B-242**

**Dallas, TX 48093**

**Phone: 214-739-1706**

**HIPAA Acknowledgement and Consent Form**

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

**Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**

**Obtain payment from designated third-party payers.**

**Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.**

**I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the office website** [**https://verditexas.com/**](https://verditexas.com/) **). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.**

**I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.**

**I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient /Patient Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient/ Patient Representative (please print) Relationship to Patient

**COMPANY USE ONLY:**

We attempted to obtain written acknowledgement of patients’ receipt of our Notice of Privacy

Practices, but acknowledgement could not be obtained from the patient for the following reason:

􀂉 Patient Refused to Sign

􀂉 Patient Representative Refused to Sign

􀂉 Emergency Situation Prevented Signature􀂉 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** *Last Name First Name MI*

**Social Security #** **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize** Verdi Oncology Texas /d.b.a**. Verdi Cancer and Research Center of Texas** to disclose medical information of the above-named individual as described below. This authorization is only valid at this location and for the information designated below.

**PURPOSE FOR NEED OF DISCLOSURE:**

My medical information may be disclosed to and used by the following individual or organization: Please list all persons you wish to receive your personal medical information.

**❑ Spouse**

*name address and phone, if different than patient*

**❑ Child/Children**

*name address and phone*

**Child/Children** *name address and phone*

**❑ Other**

*name and relationship address and phone*

**INFORMATION TO BE RELEASED: Please indicate below what types of information can be disclosed to the identified individual(s) listed above.**

**I understand the information listed below may be communicated via**: fax, photocopy, verbal communication, telephone, voice mail and/or direct mail.

**❑ All Clinical and Billing Information**

**If certain information is NOT to be included, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. **Right to Receive a Copy of this Authorization**- I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. **Right to Withdraw this Authorization**-I understand that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the health information management department of the Entity as listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the date / event or condition specified below.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Verdi Oncology Texas Privacy Officer at (214) 739-1706.

**If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days (60 days).**

Expiration Date

Signature of Patient or Legal Representative Date

(If signed by Legal Representative, state relationship and authority to do so) Signature of Witness

**Patient is: ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased**

**Legal Authority: ❑ Custodial Parent ❑ Legal Guardian ❑ Executor of Estate of Deceased**

**❑ Authorized Legal Representative**

**Received by: Date:**

Patient Medical History Form

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last Name(please print)** | | | **First Name** | | **M.I.** | **Today’s Date** | | |
| **Month** | **Day** | **Year** |
| **Date of Birth** | | | **Sex at birth**  □ **Male**  □ **Female** | **Reason for visit:** | | | | |
| **Month** | **Day** | **Year** |
| **Primary Care Physician:** | | | | **Preferred pharmacy: (i.e. CVS at 26 & 52)** | | | | |

**Family Medical History: Please enter *age at diagnosis* in box for those that apply.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Grandfathers** | | **Grandmothers** | | **Parents** | | **Siblings** | | **Children** | |
| **Maternal** | **Paternal** | **Maternal** | **Paternal** | **Mother** | **Father** | **Sister** | **Brother** | **Daughter** | **Son** |
| **High Blood pressure** |  |  |  |  |  |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |  |  |
| **Anemia/Blood disorder** |  |  |  |  |  |  |  |  |  |  |
| **Other: Please specify below** |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Cancer:** |  |  |  |  |  |  |  |  |  |  |
| **Breast** |  |  |  |  |  |  |  |  |  |  |
| **Ovarian** |  |  |  |  |  |  |  |  |  |  |
| **Colon** |  |  |  |  |  |  |  |  |  |  |
| **Lung** |  |  |  |  |  |  |  |  |  |  |
| **Prostate** |  |  |  |  |  |  |  |  |  |  |
| **Other: Please specify below** |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

**Hospitalizations/Surgeries: Please list all hospitalizations and surgeries**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Date | Reason for Hospitalization or Type of Surgery | Where | Doctor |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Personal Medical History: Please mark box with an “X” for all that apply and include date of onset.**

|  |  |  |
| --- | --- | --- |
| **“X”** | **Diagnosis** | **Date of onset** |
| □ | Anemia |  |
| □ | Arthritis |  |
| □ | Asthma |  |
| □ | Blood Disorder/Clotting Disorder |  |
| □ | Cancer (please list type) |  |
|  | 1. |  |
| 2. |  |
| 3. |  |
| □ | Diabetes |  |
| □ | Emphysema/COPD |  |
| □ | Epilepsy |  |
| □ | Exposure to Asbestos |  |
| □ | Heart Disease (e.g. Heart Attack) |  |
| □ | High Blood Pressure |  |
| □ | Hepatitis Type: \_ |  |

|  |  |  |
| --- | --- | --- |
| **“X”** | **Diagnosis** | **Date of onset** |
| □ | Kidney Disease |  |
| □ | Liver Disease |  |
| □ | Mental Illness |  |
| □ | Migraine Headaches |  |
| □ | Pneumonia |  |
| □ | Sexually Transmitted Disease |  |
| □ | Sleep Apnea |  |
| □ | Stroke |  |
| □ | Thyroid Disease |  |
| □ | Tuberculosis |  |
| □ | Stomach Ulcer |  |
| □ |  |  |
| □ |  |  |
| □ |  |  |
| □ |  |  |

**Previous Cancer Treatments:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility/Physician Name** | **City/State** | **Phone number** | **Type of treatment (i.e. chemotherapy, radiation)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Social History:**

**Do you have children?** □Yes □No If yes, how many children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you wish to have children?** □ Yes □No

**Have you served in the military?** □Active □Inactive □ No If yes indicate dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a living will\*?** □Yes □No

**Do you have a durable power of attorney for healthcare\*?** □Yes □No

**Do you have a Do Not Resuscitate (DNR) order\*?** □Yes □No

\*If you have any of the above please bring in the documentation so we may add that to your chart.

**Are you sexually active?** □ Yes □No

**Are you using birth control?** □ Yes □No If yes, please include type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently use tobacco products?** □Yes **□** No

If yes, use per day: □cigarettes: \_\_\_\_ □cigars: \_\_\_\_ □pipe: \_\_\_\_ □chewing tobacco: \_\_\_\_

For how many years have you used the above tobacco product? \_\_\_\_\_\_\_\_\_\_

If no, have you ever used tobacco products in the past? □Yes □No

If yes, use per day: □cigarettes: \_\_\_\_ □cigars: \_\_\_\_ □pipe: \_\_\_\_ □chewing tobacco: \_\_\_\_

For how many years did you use the above tobacco product? \_\_\_\_\_\_\_\_\_\_

When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_

**How many servings of wine, beer, or other alcoholic beverage(s)** do you drink per day? \_\_\_\_\_per week? \_\_\_\_\_\_\_\_

Do you have a history of alcoholism? □Yes □No

**Have you used illicit substances in the past year**? □Yes □No

If yes, please list what using, how often, and for how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening tests:**

**Colonoscopy:** □ Yes □NoIf yes, when: \_\_\_\_\_\_\_\_\_\_

**Fecal immunochemical test (FIT or Cologuard®)** □ Yes □NoIf yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Mammogram (female)**: □ Yes □NoIf yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Allergies:**

**Are you allergic to any medications**? □ Yes □No

If yes, please list the medications that you are allergic to and the type of reaction you experienced.

|  |  |
| --- | --- |
| **Drug** | **Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Are you allergic to any of the following?**

**Latex**: □ Yes □No

**Tape**: □ Yes □No If yes, please list the type of tape:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eggs**: □ Yes □No

**Vaccines**: □ Yes □No If yes, please list the type of vaccine: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other allergies**: □ Yes □No

If yes, please list other allergies**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Immunizations**:

Please enter date of last vaccine received. Enter N/A if not applicable to you.

|  |  |
| --- | --- |
| **Immunization** | **Date of last vaccine (if known)**  **Enter N/A if not applicable** |
| **Seasonal Influenza (Flu)** |  |
| **Pneumococcal (pneumonia)** |  |
| **Diphtheria/Pertussis/Tetanus** |  |
| **Haemophilus influenzae type b (Hib)** |  |
| **Hepatitis B** |  |
| **HPV** |  |
| **Measles** |  |
| **Measles/Mumps/Rubella (MMR)** |  |
| **Polio** |  |
| **Shingles** |  |
| **Smallpox** |  |
| **Tetanus only** |  |
| **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

**Blood Transfusions**:

Have you ever had a blood transfusion: □ Yes □No

If yes, date of last blood transfusion and product received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have a reaction: □ Yes □No

**Pain**:

Do you have pain? □ Yes □No

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain: □dull □sharp □throbbing □aching □shooting □burning □tingling □other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does pain come and go or is it constant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment have you already received for this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If taking medication for above issue who is prescriber? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently having pain? □ Yes □No

Rate your pain (1 for mild pain or discomfort to 10 for worst pain ever experienced). 1 2 3 4 5 6 7 8 9 10

Mild ---------------------------Severe

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications**: **Please list current prescribed and over-the-counter medications. Include any vitamins, herbals, supplements, and items used on an as needed basis.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Medication | Dosage | Frequency |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **5.** |  |  |  |
| **6.** |  |  |  |
| **7.** |  |  |  |
| **8.** |  |  |  |
| **9.** |  |  |  |
| **10.** |  |  |  |
| **11.** |  |  |  |
| **12.** |  |  |  |
| **13.** |  |  |  |
| **14.** |  |  |  |
| **15.** |  |  |  |
| **16.** |  |  |  |
| **17.** |  |  |  |
| **18.** |  |  |  |
| **19.** |  |  |  |
| **20.** |  |  |  |
| **21.** |  |  |  |
| **22.** |  |  |  |
| **23.** |  |  |  |
| **24.** |  |  |  |
| **25.** |  |  |  |
| **26.** |  |  |  |
| **27.** |  |  |  |
| **28.** |  |  |  |
| **29.** |  |  |  |
| **30.** |  |  |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OB/Gyn History(female patients)**

|  |  |
| --- | --- |
| **Age at first period:** |  |
| **Date of last PAP smear:** | Was it normal? □ Yes □No |
| **Are you still having periods?** | □ Yes □No |
| ***If yes* : Date of last period:** |  |
| **What is your usual duration of flow?** | days |
| **Periods occur every :** | days |
| **Symptoms with periods:** | □ Menstrual pain  □Bleeding between periods  □spotting between periods  □excessive bleeding  □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***If No*: Age at last period?** |  |
| **Any bleeding after menopause?** | □ Yes □No |

|  |  |
| --- | --- |
| **Number of pregnancies:** |  |
| **Age at birth of first child?** |  |
| **Number of live births:** |  |
| **Number of miscarriages/abortions:** |  |
| **Any complications during pregnancy?** | □ Yes □No  If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Did you breast feed?** | □ Yes □No If yes, how long? |
| **Are you or could you currently be pregnant?** | □ Yes □No |

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verdi Cancer and Research Center of Texas**

**PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION**