Millennium Cancer Center

LIFE MATTERS

# NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire by answering each question as accurately as possible.

## GENERAL INFORMATION

Patient Name: _____ Date of Birth:_____ Sex: Male Female

Aadhar #: _____ - _____ - _____ Insurance Carrier:_____ Insurance ID#:_____

Address: _____ Phone: (____)_____-_____ Mobile: (____)_____-_____

Referring Physician: _____ Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other_____

## 1) CHIEF COMPLAINT/REASON FOR VISIT

a) What is the reason for your visit today? _____

b) Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location

_____

**If you marked yes**, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain **1 2 3 4 5 6 7 8 9 10**

## 2) MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

| Medication Name (Generic Component) | Dose (ex. 50mg) | Frequency (ex. once a day) | Remarks |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 3) ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____

Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction_____

Any other allergies? Incl. Latex **YES** **NO** if yes please list_____

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## SOCIAL HISTORY

**1)** Do you or have you EVER used tobacco products? (circle one) **YES** or **NO**, if yes please complete 1A – 1B, in no skip to 2.

**1A**. Select All That Apply:

- ☐ Current smoker, every day
- ☐ Current smoker, some days
- ☐ Smoker, status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Former Smoker

**1B.** Select All That Apply:

- ☐ Cigarettes Amount:_____ per day
- ☐ Cigars Amount:_____ per day
- ☐ Smokeless Amount:_____ per day
- ☐ Pipes Amount:_____ per day

**2)** Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

**3)** Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

## FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

| | | | | |
|---|---|---|---|---|
| Mother: | **Alive** | **Deceased** | Age:_____ | Medical Condition:_____ |
| Father: | **Alive** | **Deceased** | Age:_____ | Medical Condition:_____ |
| Sister(s): | **Alive** | **Deceased** | Age:_____ | Medical Condition:_____ |
| Brother(s): | **Alive** | **Deceased** | Age:_____ | Medical Condition:_____ |
| Grandmother: | **Maternal** | **Paternal** | Age:_____ | Medical Condition:_____ |
| Grandfather: | **Maternal** | **Paternal** | Age:_____ | Medical Condition:_____ |
| Aunts: | **Maternal** | **Paternal** | Age:_____ | Medical Condition:_____ |
| Uncles: | **Maternal** | **Paternal** | Age:_____ | Medical Condition:_____ |

## PAST MEDICAL HISTORY

**1)** Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

- ☐ Pet Scan When_____ Where_____
- ☐ CT Scan When_____ Where_____
- ☐ Ultrasound When_____ Where_____
- ☐ Other (specify) When_____ Where_____

**2)** Have you been hospitalized in the last 6 months? **YES** **NO**
If YES, when_____ and reason for hospitalization _____

**3)** Please list any additional information about your medical history that the physician should know:

_____

_____

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## REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

**GENERAL**
__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Excessive Weight Gain or Loss
__ Fever
__ Headache
__ Numbness

**CARDIOVASCULAR**
__ Chest Pain
__ High/Low Blood Pressure
__ Irregular/Rapid Heart Beat
__ Poor Circulation
__ Shortness Of Breath
__ Swelling In Ankles
__ Varicose Veins

**SKIN**
__ Any Chronic Rashes Or Eruptions
__ Change In Moles
__ Hives
__ Itching
__ Irregular Scars
__ Poor Healing Of Lesions or Wounds
__ Poor Healing Of Foot Lesions

**EYE, EAR, NOSE, & THROAT**
__ Bleeding Gums
__ Blurred Vision
__ Crossed Eyes
__ Difficulty Swallowing
__ Double Vision
__ Earache Or Ear Discharge
__ Hay Fever
__ Hoarseness
__ Loss of Hearing
__ Nosebleeds
__ Persistent Cough
__ Ringing In Ears
__ Sinus Problems
__ Vision – Flashes or Halos

**GASTROINTESTINAL**
__ Bloating
__ Black Or Tarry Stools
__ Bowel Changes
__ Change In Appetite
__ Constipation
__ Diarrhea
__ Excessive Thirst
__ Gas
__ Hemorrhoids
__ Indigestion/Heartburn
__ Nausea
__ Rectal Bleeding
__ Stomach Pain
__ Vomiting

**HEMATOLOGIC**
__ Anemia
__ Easy Bruising
__ Excessive Bleeding

**RESPIRATORY**
__ Chronic Cough
__ Coughing Up Blood
__ Wheezing Or Asthma

**URINARY**
__ Blood In Urine
__ Frequent Urination
__ Lack Of Bladder Control
__ Painful Urination

**NEUROLOGICAL**
__ Double Vision/Vision Loss
__ Prior Stroke
__ Muscular Weakness/Tingling
__ Speech Difficulty
__ Transient Paralysis
__ Transient Neurologic Deficit

**MUSCLE/BONE/JOINT**
Pain, Weakness, Numbness In:
__ Arms
__ Back
__ Feet
__ Hands
__ Hips
__ Legs
__ Neck/Shoulders

**MEN ONLY**
__ Erection Difficulties
__ Lump In Testicles
__ Penis Discharge
__ Sore On Penis
__ Other Issue_____

**WOMEN ONLY**
__ Abnormal Pap Smear
__ Bleeding Between Periods
__ Breast Lump
__ Extreme Menstrual Pain
__ Hot Flashes
__ Nipple Discharge
__ Painful Intercourse
__ Vaginal Discharge

Date of Last Period: _____
Date of Last Pap Smear: _____
Date of Last Mammogram:_____

Are you pregnant? Yes or No

Number of Children: _____

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# NEW PATIENT MEDICAL QUESTIONNAIRE

## REVIEW OF SYSTEMS CONTINUED

Check all the conditions you have or have had in the past.

| | | | |
|---|---|---|---|
| __ Aids | __ Chicken Pox | __ HIV Positive | __ Polio |
| __ Appendicitis | __ Diabetes | __ Kidney Disease | __ Prostate Problem |
| __ Arthritis | __ Emphysema | __ Liver Disease | __ Rheumatic Fever |
| __ Asthma | __ Epilepsy | __ Measles | __ Scarlet Fever |
| __ Bleeding Disorders | __ Glaucoma | __ Migraine Headaches | __ Stroke |
| __ Breast Lump | __ Heart Disease | __ Multiple Sclerosis | __ Thyroid Problems |
| __ Cancer | __ Hepatitis | __ Mumps | __ Tuberculosis |
| __ Cataracts | __ Herpes | __ Pacemaker | __ Ulcers |
| __ Chemical Dependency | __ High Cholesterol | __ Pneumonia | __ Venereal Disease |

## SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

**Signature of Patient or Personal Representative** **Date**

_____ _____

**Print Name of Patient or Personal Representative** **Relationship to Patient**

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# PATIENT AUTHORIZATION
# TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

**I wish to be contacted in the following manner *(Check All That Apply):***

☐ **Home Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Work Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Cell Telephone**
- ○ Leave message with detailed information.
- ○ Only leave message with call back details.

☐ **Written Correspondence**
- ○ Mail to my home address on file.
- ○ Mail to my work/office address:

_____
_____

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

**Authorized Designees:**

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

***This authorization shall remain in effect from the date signed below until revoked.***
***You have the right to revoke this authorization in writing.***

- ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.***
- ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.***

_____ _____ _____
Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

_____ _____
Patient/Legal Representative Signature Date

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# GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

**MEDICAL CONSENT:** I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Millennium Cancer Center and his/her designees as directed in his/her judgement.

**RIGHT TO REFUSE TREATEMENT:** I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

**ADVANCE DIRECTIVES**: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

**RELEASE OF MEDICAL INFORMATION**: I authorize Millennium Cancer Center to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Millennium Cancer Center. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

**FINANCIAL AGREEMENT**: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Millennium Cancer Center for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Millennium Cancer Center will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Millennium Cancer Center** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

**MEDICARE CERTIFICATION**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

**By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.**

| _____ | _____ | _____ |
|---|---|---|
| Patient /Legal Representative Name (Print) | Patient/Legal Representative Signature | Date |

**For Millennium Cancer Center Use Only**

Complete this section, if this form is not signed and dated by the patient or patient's legal representative.

**I have made a good faith effort to obtain a written acknowledgement of receipt of Millennium Cancer Center Notice of Privacy Practices but was unable to do so for the following reason:**

____ Patient refused to sign ____ Patient unable to sign ____ Other Reason (Describe):_____

| _____ | _____ |
|---|---|
| Employee Name | Date |