Today's Date _________

COMPREHENSIVE
CANCER CENTERS

Patient Questionnaire

Patient Name: ____________________________ Age: __________

Referred by: _______________________ Primary Care Physician: ____________________

OB/GYN: _________________________ Surgeon: ________________________________

Other Physicians: ____

Problems that have led patient to seek medical attention here (check)?

___ Abnormal mass/lump ___ Abnormal breast mass/lump ___Abnormal scan/mammogram

___ Poor breathing ___ Cough ___ Pain ___Weight Loss ___ Abnormal Lab

Other:

____

Medical History

Please check if you have a history of any of the following

	Yes	No			Yes	No
Heart attack				Congestive heart failure		
Kidney disease				Other heart disease		
Liver disease				High blood pressure		
Tuberculosis				Lung problems		
Seizures				Thyroid disease		
Diabetes				Phlebitis		
Emphysema/COPD				Stomach problems		
Arthritis				Skin disease		
Previous Cancer Type?				Pain: location ______ Mild: ___ Moderate: ___ Severe: ____		

Surgical History

Surgeries	Date	Surgeries	Date
_____________________	_________	_____________________	_________
_____________________	_________	_____________________	_________
_____________________	_________	_____________________	_________

Previous Transfusions yes___ no___ Transfusion reaction yes___ no___

Allergies

Medication(s) = allergic reaction

1.___________=___________ 2.__________=__________ 3 .__________=___________

Current Medications

Medication Dose Frequency | Medication Dose Frequency

1.________________________________ 6.________________________________

2.________________________________ 7.________________________________

3.________________________________ 8.________________________________

4.________________________________ 9.________________________________

5.________________________________ 10.________________________________

Family History

Family Member	Living/Age	Deceased/Age	Health Status or Cause of Death
Father			
Mother			
Brothers #|			
Sisters #			

Please list any other family members who have had cancer and type of cancer:

____

____

Social History

Are you currently: Employed Retired Unemployed On Disability

Occupation: ______________________________

Circle one: Single Married Divorced Widowed Separated

Occupation of others in household: ____

Children: # of Sons: _____ Ages: ____________ Illness: _________________________

# of Daughters: _____ Ages: ____________ Illness: __________________

Have you ever smoked? _______________ If yes, your age when you started: _______

Average packs per day: ________ Date quit (if applicable): ________

Do you drink alcohol? _________ What type: __________ How much per week? ____________

Did you ever drink large amounts of alcohol? _________ Date quit (if applicable): ________

GYN/OB History (women only)

Date of last menstrual period ________ Last Pap smear _________

Last mammogram _____________ Last bone density/osteoporosis scan _________

Are you currently pregnant? _____ Could you possibly be pregnant? _______

Pregnancies _____ # Live births ______ Age at first pregnancy ______ Age at menopause ______

Birth control pills? Yes___ No_____ Name ________________ Dates ______________

Fertility medicines? Yes___ No_____ Name ________________ Dates ______________

Hormone Medicine

Replacement therapy? Yes___ No____ Name ________________ Dates ______________

Review of Systems

General	Yes	No		Yes	No
Hot flashes			Fatigue		
Fevers			Night sweats		
Weight gain # pounds			Weight loss # pounds		
Poor appetite					

Eyes	Yes	No		Yes	No
Cataracts			Double vision		
Blurred vision			Glaucoma		
Vision Loss			Floaters		

Head and Neck	Yes	No		Yes	No
Mouth pain/ulcers			Post nasal drip		
Sinusitis/sinus pain			Hearing loss		
Difficulty swallowing			Hoarse voice		

Cardiovascular	Yes	No		Yes	No
Chest pain			Heart murmur		
Palpitations			Ankle swelling		
Calf pain			Light headed		

Pulmonary System	Yes	No		Yes	No
Cough			Shortness of breath		
Coughing blood			Pain with breathing		
C-PAP			Wheezing		
Sputum					

Gastrointestinal	Yes	No		Yes	No
Nausea			Yellow skin (Jaundice)		
Vomiting			Clay colored stool		
Constipation			Blood in stool		
Diarrhea			Abdominal pain		
Vomiting blood			Black stool		
Difficulty swallowing			Heartburn		
Colonoscopy			Date of colonoscopy __________ Normal? ________		

GYN	Yes	No		Yes	No
Vaginal Discharge			Vaginal bleeding		

Nervous System	Yes	No		Yes	No
Headaches			History of stroke		
Dizziness			History of seizures		
Paralysis			Speech disturbance		

	Yes	No		Yes	No
Tremors					
Loss of sensation			Weakness of arm/leg		
Mental Illness			Passing out		
Tremors					

Musculoskeletal System	**Yes**	**No**		**Yes**	**No**
Arthritis			Red or swollen joints		
Bone pain			Muscle pain		
Spine pain			Arm or leg swelling		

Hematologic	**Yes**	**No**		**Yes**	**No**
Gum or nose bleeding			Treatment for anemia		
Enlarged lymph nodes			Bruising		

Genitourinary System	**Yes**	**No**		**Yes**	**No**
Pain with urination			Urgent urination		
Blood in urine			Incontinence		
Frequent urination			Night time urination _____X		

B/P: ______ T: ______ P: _____ R: _____ Wt: _____ Ht: _____ BSA: _____ O2Sat: _____

Date:_____________ RN/MA: _________________________

COMPREHENSIVE
CANCER CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Comprehensive Cancer Centers of Nevada 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 with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.

Date: ____________________________________

Name: ____

Signature: ____

Name of Personal Representative *(if appropriate)*: ____

Signature of Personal Representative *(if appropriate)*: ____

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received:)____ -OR-

Reason acknowledgment was not obtained: ____

____

____

____

COMPREHENSIVE
CANCER CENTERS

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between ____________________________ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____________________________	________________________	_________________________

Name	Phone	Relationship
_____________________________	________________________	_________________________
_____________________________	________________________	_________________________
_____________________________	________________________	_________________________
_____________________________	________________________	_________________________

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____________________________	________________________	_________________________
Patient Signature	SS #	Date

COMPREHENSIVE
CANCER CENTERS

Meaningful Use Update

Name: ____

Date of Birth: ____

Race/Ethnicity: ____

Preferred Language: _____________________________________

Preferred Method of Contact

Email: ____

Cell: ____

Home: ____

Other: ____

Marital Status

Married	Single	Widowed
Divorced	Life Partner	

COMPREHENSIVE CANCER CENTERS

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

____
Patient Name
(First Name, Middle Initial, Last Name)

____
Date of Birth of Patient

☐ **I do not have e-mail access.**

☐ **I do not want access to the portal.**

Authorized user is:

☐ Patient

☐ Patient's Guardian (or parent of un-emancipated minor patient)

☐ Person authorized to make decisions on behalf of patient (*e.g.* by a medical power of attorney)

____
Authorized User Name (If different from patient)

____
Email Address of Patient or Authorized User

____
Physician's Name

____
Authorized Signature

____
Date

____
Signature of Practice Staff
[Confirming user's identity and authority]

____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_______________
Email in PMS_________	iKM Consent_______