

**MEDICAL ONCOLOGY
& HEMATOLOGY**

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RADIATION ONCOLOGY

Steven J. Westgate, M.D.
Mark P. Bryer, M.D.
Joseph Bean, M.D.
Jay Allen, M.D.
William E. Decker, M.D.
John H. Bechtel, M.D.

RADIATION THERAPY

(573) 442-5525

PHARMACY

(573) 817-8527

BUSINESS OFFICE

(573) 875-7082

This information is intended to provide you with the paperwork required for your new patient registration. Please complete these forms and bring them with you to your appointment. Please also bring your insurance cards and we will make a photocopy of them for our records. **We also need you to bring your current medications with you to the appointment including prescription and over the counter medications.**

Instructions for the Assignment of Benefits/Financial Responsibilities Form:

1. Please fill out each line of the form.
2. If you are employed, please list it on the form under employer, if you are retired, you can list retired.
3. For the emergency contact, please list someone outside of your home, not a spouse. List either a family member or a friend that has a different phone number than you.
4. Please sign and date the form at the bottom of the page.

The notice of privacy packet is about the Health Information Portability and Accountability Act, better known as HIPAA. It is a Federal Law which went into effect on April 14, 2003 and tells you about how your rights to privacy will be observed. Please take the time to read this packet and keep it for your files for future reference.

Instructions for the Acknowledgment of Receipt of Privacy Practices:

1. Print your name, date of birth, and the date you are completing the form.
2. Sign in the section under Signature.

Instructions for the Medical History and Current Medicines and Symptoms:

1. Fill out all information regarding you and your family history.
2. Make sure and complete all pages of the fold out of both forms.

Thank you for your cooperation. If you have any questions or concerns, you can contact our scheduling desk at 573-875-7081 or toll free at 1-866-724-2413 and select option 3 for scheduling.

Missouri Cancer Associates

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____
Last First M.I.
() ()
Home Telephone Cell phone

Home Address: _____ Mailing Address: _____
Street Street
City State Zip City State Zip

DOB: _____ Age _____ M F SS# _____
Sex Married Single Divorced Widowed Other
Check Marital Status

Employer: _____ ()
Name Telephone
Address Occupation

Responsible Party: _____ ()
Name Relationship Telephone

Emergency Contact:
Must be outside of your home: _____ ()
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

MCA Physician: _____ Your Email Address: _____

Primary Ins: _____ Telephone: ()

Insured Name: _____ DOB _____ Group # _____ Policy # _____

Secondary Ins: _____ Telephone: ()

Insured Name: _____ DOB _____ Group # _____ Policy # _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Missouri Cancer Associates.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Missouri Cancer Associates. This assignment covers any and all benefits under Medicare; other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Missouri Cancer Associates.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Missouri Cancer Associates.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Signature _____ Date/Time _____ AM or PM (circle one)

Responsible Party Signature _____ Relationship _____ Date/Time _____ AM or PM (circle one)

The Patient above also authorizes the disclosure of health and financial information to:
Spouse Children Parents Step Parents/Children Contracted Care Giver/Guardian
Name of Person(s): _____
Day phone number: _____
Please initial and date this section: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Missouri Cancer Associates 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 Missouri Cancer Associates.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SIGNATURE: _____

NAME OF PERSONAL REPRESENTATIVE (if appropriate): _____

SIGNATURE OF REPRESENTATIVE (if appropriate): _____

DATE: _____

-----Missouri Cancer Associates Use Only -----

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

**MISSOURI
CANCER
ASSOCIATES, LLC**

■ Medical and Radiation Oncology ■ Hematology ■

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To all Patients of Missouri Cancer Associates

The Notice of Privacy has been sent to you to comply with the Federal Law known as HIPPA. One of our physicians at Missouri Cancer Associates was requested to consult with you while you were hospitalized.

This Privacy Notice provided you with the information as to how your medical information may be disclosed and how you can obtain access to this information. We are required by Federal Law to maintain the privacy of your health information.

The effective date of this Privacy Notice is April 14, 2003

If you have any questions please contact our Privacy Officer, Marty Heath at 573-817-8547 or toll free number 1-866-724-2413

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us

In this Notice, we use terms like “we,” “us” or “our” to refer to Missouri Cancer Associates, its physicians, employees, staff and other personnel. All of the sites and locations of Missouri Cancer Associates follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance

company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Fundraising Activities: We may use your demographic information, such as name, address and phone number, and the dates you received services from us, to contact you in an effort to raise money for charitable purposes. We may also disclose this information to a foundation related to the practice so that the foundation may contact you to raise money for the foundation. **If you do not want the practice or foundation to contact you for fundraising activities, please notify Marty Heath /Privacy Officer/Missouri Cancer Associates, 1705 E. Broadway, Ste 100 Columbia, MO 65201/ 573-874-7800 or toll free at 866-724-2413.**

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify Marty Heath / Privacy Officer /573-874-7800 or toll free at 866-724-2413.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **We are not**

required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to Marty Heath / Privacy Officer / Missouri Cancer Associates, 1705 E. Broadway Suite 100, Columbia, MO 65201.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to Marty Heath / Privacy Officer/ Missouri Cancer Associates, 1705 E. Broadway Suite 100 Columbia, MO 65201 We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Marty Heath / Privacy Officer / Missouri Cancer Associates, 1705 E. Broadway suite 100 , Columbia, MO 65201. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Marty Heath / Privacy Officer/ Missouri Cancer Associates, 1705 E. Broadway suite 100 Columbia, MO 65201.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Marty Heath / Missouri Cancer Associates, 1705 E. Broadway suite 100 Columbia, MO 65201. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of


the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact Marty Heath / Privacy Officer/ Missouri Cancer Associates, 1705 E. Broadway suite 100 Columbia, MO 65201. You may also obtain a paper copy of this Notice at our web site, www.missouricancer.com.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Marty Heath / Privacy Officer/ Missouri Cancer Associates, 1705 E. Broadway suite 100 Columbia, MO 65201/ 573-874-7800 or toll free at 866-724-2413 . You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in patient waiting rooms. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our web site, www.missouricancer.com.

 **MISSOURI
CANCER
ASSOCIATES, LLC**

■ Medical and Radiation Oncology ■ Hematology ■

MEDICAL HISTORY

Name: _____ Date of Birth: _____

FAMILY HISTORY

Father Alive (Age ____) Deceased (Age ____) Cause of death: _____ Unknown

Mother Alive (Age ____) Deceased (Age ____) Cause of death: _____ Unknown

	Number Alive	Approximate Age(s)	Number Deceased	Approximate Age(s) of Death	Cause of Death	
Brothers	_____	_____	_____	_____	_____	<input type="checkbox"/> Unknown
Sisters	_____	_____	_____	_____	_____	<input type="checkbox"/> Unknown
Sons	_____	_____	_____	_____	_____	<input type="checkbox"/> Unknown
Daughters	_____	_____	_____	_____	_____	<input type="checkbox"/> Unknown

Illness/Conditions	None	Father	Mother	Brothers	Sisters	Sons	Daughters	Describe
Colon cancer or polyps								
Breast or ovarian cancer								
Other type cancer (lung, prostate, kidney, etc.)								
Blood clots								
Anemia or other blood problems								
Diabetes								
High blood pressure								
High cholesterol or triglycerides								
Heart disease								
Stroke/TIA								
Anxiety, depression or psychiatric illness								
Tuberculosis (TB)								
Anesthesia complications								
Genetic disorders								
Other - describe								

SOCIAL HISTORY

How many years of school have you completed? _____

Are you disabled? No Yes ⇔ _____

Your current employment status: Employed Retired Unemployed Homemaker

Current or previous occupation: _____

Are you married? No Yes

Do you live alone? No Yes

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long (years)	Year stopped?
Cigarettes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Alcohol (beer/wine)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Recreational/Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			

Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (✓) in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	<u>No</u> <u>Problem</u>	<u>Medical</u> <u>Problem</u>	<u>Surgery</u>	<u>Year(s) of</u> <u>Surgery</u>	<u>Describe</u>
Eyes (cataracts, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, nose, sinuses, or tonsils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid or parathyroid glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart valves or abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Coronary (heart) arteries (angina)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arteries (aorta, arteries to head, arms, legs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Veins or blood clots in the veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Esophagus or stomach (ulcer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bowel (small & large intestine) or appendix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver or gallbladder (including hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lymph nodes or spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bones, joints or muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, neck or spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Females: uterus, tubes, ovaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Males: prostate, penis, testes, vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY (continued)

Have you ever had any of the following?	<u>NO</u>	<u>YES</u>	<u>Describe the problem when appropriate</u>
Abnormal chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia complications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety, depression or mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood problems (abnormal bleeding or anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polyp or tumor removed from colon or rectum	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol or tryglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Treatment of alcohol and/or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis or positive skin test for TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cosmetic or plastic surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood or blood product transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scleroderma or connective tissue disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation (Cobalt or radioactive implants) therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy or immunotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____

FEMALE PATIENTS ONLY:

	<u>NO</u>	<u>YES</u>
Have you ever taken birth control pills or hormone replacement? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an abnormal Pap smear? _____ <input type="checkbox"/> Unknown	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced menopause or had a hysterectomy? _____	<input type="checkbox"/>	<input type="checkbox"/>
If no: Are you concerned about your menstrual periods? _____	<input type="checkbox"/>	<input type="checkbox"/>
Might you be pregnant at this time? _____	<input type="checkbox"/>	<input type="checkbox"/>
Date of onset of your last menstrual period: mo: _____ yr: _____ yr: _____		
Approximate date of your last Pap smear and pelvic exam: mo: _____ yr: _____ <input type="checkbox"/> Never		
Approximate date of your last mammogram: mo: _____ day: _____ <input type="checkbox"/> Never		
Number of: Pregnancies _____ Live Births _____		
Your age at first pregnancy _____		
Your age at first menstrual period _____		

 **MISSOURI
CANCER
ASSOCIATES, LLC**

■ **Medical and Radiation Oncology** ■ **Hematology** ■

CURRENT MEDICINES AND SYMPTOMS

MISSOURI CANCER ASSOCIATES

Name: _____ Date of Birth: _____

What would you like to talk to the doctor about today? _____

MEDICATION

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications?

No Yes → List medications below or attach your own list.

Name of Medication	Dose	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications?

No Yes → List below

Name of Medication	Describe Allergic Reaction	Have you had an allergic reaction to:
_____	_____	Iodine or x-ray contrast dye <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	Latex or rubber <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	Bee or wasp stings <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	Adhesive tape <input type="checkbox"/> No <input type="checkbox"/> Yes

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side affects?

No Yes → _____

List any food allergies _____ None

Name: _____ Date of Birth: _____

SYSTEMS REVIEW

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking (✓) "No" or "Yes" for each question. Circle the symptoms(s) you have experienced when multiple symptoms are listed in a question.

	<u>NO</u>	<u>YES</u>
Skin rash, sore, excessive bruising or change of a mole?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or urination?	<input type="checkbox"/>	<input type="checkbox"/>
Change in sexual drive or performance?	<input type="checkbox"/>	<input type="checkbox"/>
Significant headaches, seizures, slurred speech or difficulty moving an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems such as double or blurred vision, cataracts or glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Diminished hearing, dizziness, hoarseness or sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
(If yes: <input type="checkbox"/> Full <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial)		
Bothered with cough, shortness of breath, wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up sputum or blood?	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
"Blacked out" or lost consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or pressure, rapid or irregular heartbeats, or known difficulty with a heart valve?	<input type="checkbox"/>	<input type="checkbox"/>
Awakening at night with shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal swelling in the legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the calves of your legs when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Significant problems with constipation, diarrhea, blood/changes in bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>
Approximate date of your last colon or rectum x-ray or instrument examination (proctoscopy, sigmoidoscopy, colonoscopy)? Date: _____ <input type="checkbox"/> Never		
Difficulty starting your urinary stream, completely emptying your bladder or leaking urine from your bladder?	<input type="checkbox"/>	<input type="checkbox"/>
Burning or pain when urinating?	<input type="checkbox"/>	<input type="checkbox"/>
Pain, stiffness or swelling in your back, joints or muscles?	<input type="checkbox"/>	<input type="checkbox"/>
Fever within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands (lymph nodes)?	<input type="checkbox"/>	<input type="checkbox"/>
Feel you are at risk for HIV or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any exposure to hazardous materials?	<input type="checkbox"/>	<input type="checkbox"/>
Experiencing an unusually stressful situation?	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss of more than 10 pounds during the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Problems falling asleep, staying asleep, sleep apnea or disruptive snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal nipple discharge or a breast lump?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt a need to cut down on your alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>
Do relatives / friends worry or complain about your alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been physically, sexually, or emotionally abused?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received the pneumonia vaccine (pneumovax)?	<input type="checkbox"/> Unknown	<input type="checkbox"/>
		(Year _____)
Have you received a Tetanus / Diphtheria shot within the last 10 years?	<input type="checkbox"/> Unknown	<input type="checkbox"/>
		(Year _____)
Did you receive a Flu shot last fall?	<input type="checkbox"/>	<input type="checkbox"/>