PATIENT INITIAL HISTORY QUESTIONNAIRE

PENINSULA Radiation Oncology CENTER

Name:	Date of Birth:	Age:
Street:		
City:	Please Provide Us With the Names of Your Physicians	
Mailing:	Family Physician	
Preferred Nickname:	Referring Physician	
Day Phone:	Medical Oncologist	
Work Phone:	Other Physician	
Cell Phone:	Other Physician	
Can we leave a message on your voice mail? ❒ Yes ❒ No	Can we call you at work? ❒ Yes ❒ No	

Before you were referred did you know there was a cancer center in Soldotna? Yes No

After referral did you hear or see us anywhere else? Circle all that apply: Facebook Our Website Google Advertisements Radio Ads Other (please specify): _____

ESCORT INFORMATION

Spouse or Significant Other's name: _____

Who will accompany you on your first visit? _____

Do you wish to have your escort included in your initial meeting with the physician? ❒ Yes ❒ No

If yes, relationship and name: _____

PRIMARY PROBLEM

Please explain the reason you are here today:

_____

_____

OTHER MEDICAL SERVICES

Please check if you have seen any of the following specialists:

❒ Radiation Oncologist ❒ Medical Oncologist ❒ Surgeon ❒ None Apply

LANGUAGE

Is English your primary language? ❒ Yes ❒ No If no, list primary language. _____

Are you comfortable conversing in English? ❒ Yes ❒ Comment _____

EDUCATION

Please check level of education completed.

❒ Grammar School ❒ High School ❒ College Other: _____

PAST CANCER HISTORY

Have you ever had any of the following?

Patient Name: _____

❒ Prior Cancers ❒ Prior Radiation ❒ Prior Chemotherapy ❒ None Apply

Are you taking hormonal therapy? (i.e., Tamoxifen) ❒ No ❒ Yes If yes, what?

GENERAL HISTORY

Before my current illness, I would describe my overall health as:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

At the present time I feel:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

PAST SURGERIES *List any surgeries and year performed.* ❒ None

Past Surgery	Year	Where

PAST ILLNESSES or HOSPITALIZATION *List below with year occurred.* ❒ None

Past Illness or Hospitalization	Year	Where

MEDICATIONS *List all current medications and doses and any herbs, supplements or vitamins* ❒ None

Medication/Supplement	How Many Do You Take Daily?	Reason for Taking Medication/Supplement

ALLERGIES *List all allergies and reactions.* ❒ None

Allergy	Reaction
Vaccines Flu	❒ Yes ❒ No Date:
Pneumococcal	❒ Yes ❒ No Date:

Are you pregnant, or still want to have children? ❒ No ❒ Yes: _____

Do you use a method of birth control? ❒ No ❒ Yes: _____

Do you have lupus or scleroderma? ❒ No ❒ Yes: _____

Patient Name: _____

If you have head-or-neck cancer, who is your dentist? _____

MARITAL STATUS

❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Significant Other
❒ Living Together ❒ Available to assist _____

CHILDREN

❒ Children ❒ Alive ❒ Well ❒ Natural ❒ Adopted
# of Children _____ ❒ Lives Locally ❒ Available to assist

PRINCIPAL CARE PERSON

Name of Principal Care Person _____

Do they live with you? ❒ Yes ❒ No Relationship to patient _____
Is this person willing/able to help you? ❒ Yes ❒ No **Comment:** _____

FAMILY HISTORY

Mother • Alive • Deceased Cause _____ Age _____

Father • Alive • Deceased Cause _____ Age _____

Please list family member(s) in the appropriate box if there is a history of the following diseases(s):

Heart Disease	High Blood Pressure	Stroke	Diabetes

List other hereditary diseases: _____

FAMILY HISTORY of CANCER

Immediate		Type of Cancer	Maternal		Type of Cancer	Paternal		Type of Cancer
Mother	❒ Yes		Grandmother	❒ Yes		Grandmother	❒ Yes	
Father	❒ Yes		Grandfather	❒ Yes		Grandfather	❒ Yes	
Sister	❒ Yes		Aunt	❒ Yes		Aunt	❒ Yes	
Brother	❒ Yes		Uncle	❒ Yes		Uncle	❒ Yes	
Children	❒ Yes							

Has anyone been informed that they have ❒ BRCA1/2, ❒ LYNCH Syndrome, or ❒ other hereditary

❒ Other cancer problems. _____

WORK HISTORY

Occupation _____

Are you still working? ❒ Yes ❒ No

Were you exposed to carcinogenic substances, asbestos? ❒ Yes ❒ No List: _____

Has your illness forced you to stop working? ❒ Yes ❒ No Date:

Do you anticipate being off work? ❒ Yes ❒ No Date: _____

Has your illness forced significant other to stop working? ❒ Yes ❒ No Date: _____

Has your illness forced significant other to change hours? ❒ Yes ❒ No Date: _____

Have you applied for disability? ❒ Yes ❒ No Date: _____

Patient Name: _____

Date Disability Started: _____ Date of Application: _____

SOCIO-ECONOMIC

RELIGION (optional): _____

Special Requirements: _____

Potential Problems: _____

Transportation Problems: _____

Financial/Home Care Needs: _____

Any financial concerns staff can help with? _____

Do you have any special concerns, fears or history (such as abuse), or any sexual concerns/issues that would have an effect on your care during treatments that you wish us to know about or that you would like to speak to the physician about?

❒ Yes ❒ No If yes, Please describe: _____

COPING

Has your illness forced a change in your day-to-day activities? ❒ Yes ❒ No

Describe _____

Has your illness forced a move or a change in your living arrangement? ❒ Yes ❒ No

Describe _____

Number living in house _____ Relationship(s)

Is support system adequate to fit patient's needs? ❒ Yes ❒ No

Describe _____

PAIN

Do you have pain? ❒ Yes ❒ No

If yes, Where? _____

Please rate your current pain on a scale of 1-10. 1 being best, or no pain. 10 being worst, or intolerable.

0	1	2	3	4	5	6	7	8	9	10

What medication(s) are you taking for pain? _____

Does medication relieve pain? ❒ Yes ❒ No

When does your pain usually occur? _____

Comment: _____

EXERCISE HISTORY

Do you exercise regularly? ❒ Yes ❒ No

Type of exercise/frequency? _____

Patient Name: _____

HISTORY OF TOBACCO, ALCOHOL and DRUGS

Tobacco

☐ No ☐ Yes Ever use tobacco? How many packs per day? _____

☐ No ☐ Yes Currently use tobacco? What age started? _____

What age stopped? _____

If yes, check type(s):

☐ Cigarettes ☐ Snuff
☐ Pipe ☐ Chew
☐ Cigars ☐ Other _____

To Be Completed By MD:
Total Pack Years: _____ .

Alcohol

☐ No ☐ Yes Do you drink alcohol? If yes, how many drinks per day? _____

Drugs

☐ No ☐ Yes Currently use drugs? If yes, what drugs? _____

CURRENT CESSATION or HELP PROGRAMS

☐ No ☐ Yes Are you currently participating in any support or self-improvement programs?

If yes, ☐ Smoke Cessation Program ☐ AA ☐ NA Other _____

Would you like to participate in a smoking cessation program? _____

CURRENT WELLNESS PROGRAMS or ALTERNATIVE

☐ No ☐ Yes Are you currently participating in any alternative medicines?

☐ Yoga	☐ Chiropractic	☐ Reiki	☐ Acupuncture	☐ Holistic

PROGRAMS YOU MAY BE INTERESTED IN

☐ No ☐ Yes Would you be interested in any of the following programs or services?

☐ Look Good Feel Better	☐ Cancer Support Group	☐ Transportation Assistance	☐ Oncology Rehab

ADVANCE DIRECTIVE (Living Will)

We are required by the State to inquire.

Do you have an Advance Directive? ☐ Yes ☐ No
If yes, would you provide us with a copy for your medical record? ☐ Yes ☐ No
If you do not have an advance directive, would you like information? ☐ Yes ☐ No

Information for advance directive provided by: _____ *Date:* _____

OTHER

Please include any other information that you think is important that we know.

_____

_____

Patient Name: _____

REVIEW OF SYSTEMS: Please √ any of the items that apply to you or that you may be experiencing.

GENERAL
Normal Weight: _____
❒ Recent Weight Loss
Amount: _____
❒ Recent Weight Gain
Amount: _____
❒ Loss of appetite
❒ Fatigue
❒ Weakness
❒ Fevers
❒ Chills
❒ Night Sweats
❒ Sleep Problems

EYES
❒ Glasses
❒ Contact lenses
❒ Glaucoma
❒ Cataracts
❒ Double vision
❒ Change in vision
❒ Other vision problems

EARS/NOSE/THROAT
❒ Loss of hearing
❒ Hearing aid
❒ Ringing in ears
❒ Other ear problems
❒ Nose bleed
❒ Dentures
❒ Dental problems
❒ Frequent sore throats
❒ Hoarseness
❒ Difficulty swallowing
❒ Dry mouth
❒ Loss of taste
❒ Neck stiffness
❒ Neck pain or swelling

CARDIOVASCULAR
❒ Pacemaker
❒ Chest pain
❒ Irregular heartbeat
❒ Palpitations
❒ Hypertension
❒ Sleep sitting or propped up
❒ Short breath when lying down
❒ Fainting spells
❒ Leg pain while walking
❒ Swelling in feet
❒ Varicose veins
❒ Oxygen use at home

RESPIRATORY
❒ Shortness of breath
❒ Difficulty breathing
❒ Coughing
❒ Dry cough
❒ Coughing up sputum
❒ Coughing up blood

GASTROINTESTINAL
❒ Heartburn
❒ Nausea/upset stomach
❒ Abdominal pain
❒ Vomiting
❒ Jaundice
❒ Change in bowel habits
How long?_____
Movements per Day _____
❒ Constipation
❒ Diarrhea
❒ Blood in stool
❒ Hemorrhoids/fissures

GENITOURINARY
❒ Difficulty urinating
❒ Frequent urination
❒ Painful urination
❒ Up at night to pass urine
How Many Times _____
❒ Blood in urine
❒ Color change of urine
❒ Sexual difficulties

WOMEN ONLY
_____ Age at menarche
❒ Menopause (Age) _____
Date of last menstrual
Period:_____
_____ # of pregnancies
_____ age of first pregnancy

_____ # of live births
❒ Hot flashes _____
❒ Hormone therapy
_____ contraceptive use

MEN ONLY
❒ Impotence
❒ Difficulty with erections
❒ Penile Discharge
❒ Testicular mass
❒ Testicular pain

MUSCULOSKELETAL
❒ Leg cramps
❒ Painful muscles
❒ Painful joints
❒ Artificial joints
❒ Prosthesis
❒ Physical disabilities
❒ Gout

SKIN & BREAST
❒ Itching ❒ Blotchy
❒ Rash ❒ Scaling
❒ Sores ❒ Growths
❒ Pain in breast
❒ Color changes
❒ Lump or mass in breast or armpit
❒ Discharge or bleeding from nipple
❒ Change in nipple
❒ Nipple inversion
❒ Change in size, shape or contour

NEUROLOGICAL
❒ Headaches
❒ Tremors
❒ Memory Loss
❒ Difficulty finding words
❒ Difficulty writing
❒ Difficulty thinking clearly
❒ Numbness or tingling
❒ Dizziness
❒ Loss of consciousness
❒ Seizures
❒ Coordination
❒ Unsteady gait

PSYCHIATRIC
❒ Nervousness
❒ Anxiety
❒ Depression
❒ Change in personality
❒ Relationship problems

ENDOCRINE
❒ Excessive thirst
❒ Excessive urination
❒ Thyroid problems

HEMATOLOGIC & LYMPHATIC
❒ Swollen lymph glands
❒ Excessive bruising
❒ Excessive bleeding

I verify the above information is true and correct to the best of my belief.

Patient Signature _____ Date: _____

Reviewed by _____ Date: _____

Reviewed by Physician _____ Date: _____

PENINSULA Radiation Oncology CENTER

JOHN B. HALLIGAN, M.D.
JAMIE BLOM, M.D.
CLARE BERTUCIO, M.D.

240 Hospital Place
Soldotna, Alaska 99669
Phone: 907.262.7762

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ **Social Security #:** _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Peninsula Radiation Oncology Center

Address: 240 Hospital Place ste.101

City: Soldotna **State:** AK **Zip Code:** 99669

Phone: (907)262-7762 **Fax:** (907)262-7764

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other:

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, Chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrom), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the persons(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the persons(s) listed above.

Patient Signature: _____ **Date Signed:** _____

Notification of Disclosure to Persons Involved in Your Case

PENINSULA Radiation Oncology CENTER

Patient Name		Date of Birth	Age
Street	City	State/Zip	

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about your radiation treatments, medications, prescriptions, billing, schedule appointments or otherwise discuss any aspect of your care or treatment with anyone other than you.

If you would like us to be able to discuss information related to your care with specific persons, please list those persons below.

Name	Relationship to Patient

Patient Comments: _____

_____

I hereby authorize Peninsula Radiation Oncology Center to discuss all aspects of my treatments with the above listed persons.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Patient Financial Responsibility Agreement

PENINSULA Radiation Oncology CENTER

At Peninsula Radiation Oncology, we truly appreciate the opportunity to provide you with compassionate, state-of-the-art care. This Agreement identifies your financial obligations for all of the services you receive from us, including the services provided today and in the future. Please let us know if you do not understand any of the items discussed in this agreement.

- Please inform us of ANY and ALL insurance coverage you possess, and of any recent changes. This is crucial for proper billing and to ensure insurance coverage for our services, when available. We need correct and current information on a timely basis. If your insurance coverage changes, please contact our office immediately at 907-262-7762.
- If you do not have insurance, payment of 50% of the estimated treatment costs will be required before treatment starts. The front office coordinator will provide an estimate and payment options for you.
- You are responsible for obtaining any necessary referrals from your primary care physician and prior approval before the start of treatment if required by your insurance company. Please speak to the front office coordinator or contact our business office at 866-353-0360 if you need assistance.
- You are personally responsible to us for the full payment of all services you receive from us. All co-payments and/or deductibles for our services are due at the time of service. At your request, a financial counselor can provide you with an estimate of your financial responsibility for your treatment. However, please understand that an estimate is not binding and that the actual cost may be different. We accept payment for daily co-pays via cash, check or credit card.
- We will submit a claim to your primary and secondary insurance for all services that we provide to you. If we do not receive payment within 30 days of submission or your insurance notifies us that you are not covered under your insurance plan (e.g. the services were not pre-authorized), you will pay us the outstanding balance of the services. We will send you a statement for the amount due. If your account becomes delinquent, you agree to pay us for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs. If we eventually receive payment from your primary or secondary insurance, we will refund the difference to you.
- You authorize and direct any insurance proceeds payable for services provided by us to you to be paid directly to us, and assign to us, without recourse, all interest in and rights to claim,

collect and receive the proceeds from any insurance company providing coverage for our services. You authorize any insurance company to furnish to use and our agents any and all information pertaining to your insurance benefits and the status of any and all claims submitted by us.

- We are Medicare providers and accept assignment from Medicare. However, there may be a balance due from you after Medicare pays. Medicare law prohibits us from waiving this balance.

I have read this Agreement, understand its content, and agree to its provisions.

X

Patient Signature

PENINSULA RADIATION ONCOLOGY
240 Hospital Place, Soldotna, AK 99669
Phone: (907) 262-7762
Toll Free: (855) 333-2210
Operation Hours: 8:00 a.m. to 5:00 p.m.

Notice of Privacy Practices

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

Uses and Disclosures

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record for all health professionals who may provide treatment or who may be consulted by our staff members.

Payment. Your health information may be used to see payment from your health insurance plan, from other sources of coverage, or from credit card companies that you may use for payment of services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Peninsula Radiation Oncology Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Public Health Reporting. Your information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred prior to your notification of your decision to us.

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and or submit corrections to our protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Patient Name: {Patient.NameLFM}
MR #: {Ident.IDA} Date of Birth: {Admin.Birth_Date@d18b}

Peninsula Radiation Oncology's Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy privileges and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policy and practices may be required in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office coordinator.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to the contact person listed below.

If you believe that your privacy rights have been violated, you should call the matter to the attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filing a complaint.

Contact Person
The name and address of the person that you may contact for further information concerning our privacy practice is:

Privacy Officer
Peninsula Radiation Oncology Center
240 Hospital Place
Soldotna, AK 99669

Your signature is an acknowledgement of receipt that you have read the Notice of Privacy Practices. If you request a copy of your notice, it will be provided.

X

Patient Signature