TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Gender: ☐Male ☐Female Marital Status: (Please check one) ☐ Married ☐ Single ☐Divorce ☐Widow ☐Other:_____

Telephone (1st call): (____)_____ Telephone (2nd call): (____)_____

Referring Physician:_____
Name Address City State Zip Code

Primary Care Physician:_____
Name Address City State Zip Code

Number of Children:_____ Ages:_____

What is your primary language? _____

Who lives with you? (Please check all that apply) ☐ I live alone ☐Spouse ☐Children ☐Parents ☐Friend ☐Other:_____

Who helps at home?_____

Person(s) with your Medical Record Access: _____
Name Relationship Telephone

Have you executed a Durable Power of Attorney, Directive to Physician and/or Living Will? ☐Yes ☐No
Would you like additional information regarding these documents? ☐Yes ☐No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? ☐Yes ☐No

I am currently: Working: ☐Yes ☐No Work Schedule is: ☐Full-time ☐Part-time ☐Sick Leave ☐Retired ☐Disability

What type of work do you currently do or have done?_____

Do you use any of the following? (Please check all that apply)

Alcohol: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Sunscreen: ☐Yes ☐No

How much time do you spend exercising each week?_____ What type of exercise?_____

Do you need to use any of the following? (Please check all that apply) ☐Cane ☐Walker ☐Wheelchair ☐Oxygen

☐Other: _____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: ☐Skin ☐Mole ☐Other:_____

Female: Breast ☐Yes ☐No Have you ever been trained properly for breast self-exam? ☐Yes ☐No

Male: Testicles ☐Yes ☐No Have you ever been trained properly for testicular self-exam? ☐Yes ☐No

Are you diabetic? ☐Yes ☐No If yes, what type:_____

If yes, how is it controlled: ☐Diet ☐Oral Medications ☐Insulin ☐Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): ☐Yes ☐No If yes, how is it controlled:_____

Reproductive History:

Female: Number of pregnancies:_____ Number of children: _____ Age at first pregnancy:_____

Did you breast feed: ☐Yes ☐No If yes, how many months (approximate): _____

Age at first period:_____ Age at menopause: _____ Age at last period:_____

Hysterectomy: ☐Yes ☐No Ovaries intact: ☐Yes ☐No If *no*, please explain:_____

Hormone use: ☐Yes ☐No Sex Drive: ☐Yes ☐No Method of birth control:_____

Male: Impotence (Erectile Dysfunction): ☐Yes ☐No Sex Drive: ☐Yes ☐No

Please return completed form to the appropriate physician's office.

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What is your understanding of why you are being seen:_____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months:_____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female: Last mammogram:_____ Last bone density scan:_____
Last pap smear:_____ Last pneumonia vaccine:_____
Last colonoscopy:_____

Male: Last colonoscopy:_____ Last PSA screening:_____
Last prostate exam:_____ Last pneumonia vaccine:_____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal (P) = Paternal (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	☐Living ☐Deceased		Grandmother (P)	☐Living ☐Deceased	
Father	☐Living ☐Deceased		Grandfather (P)	☐Living ☐Deceased	
Children	☐Living ☐Deceased		Aunt(s)	☐Living ☐Deceased	
Brother(s)	☐Living ☐Deceased		Uncle(s)	☐Living ☐Deceased	
Sister(s)	☐Living ☐Deceased		Cousin(s)	☐Living ☐Deceased	
Grandmother (M)	☐Living ☐Deceased		Other:		
Grandfather (M)	☐Living ☐Deceased		Other:		

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship:_____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

Medication and Allergy List

Today's Date:_____

Patient Name:_____ _____
Last First Middle or Maiden Date of Birth

Please list ***all*** prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

(If additional space is needed then please copy this page)

Medication	Strength	Dose	How many times a day

** Allergies **

Medication (Include prescription, over-the-counter and/or vitamins)	Describe Reaction

Have you ever had an allergic reaction to: ❑ Contrast Dye ❑ Iodine ❑ Shell Fish

What type of reaction did you have: ❑ Hives ❑ Shortness of breath ❑ Other:_____

Additional Comments and/or Information:_____

Pharmacy Information

_____ (_____) _____
Pharmacy Name Phone Number

_____
Address City State Zip Code

Please return completed form to the appropriate physician's office.

CONFIDENTIAL

TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology 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 Texas Oncology Surgical Specialists.

Name: (Please Print) _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Oncology Surgical Specialists Use Only
Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____
_____
_____
_____

TEXAS ONCOLOGY

More breakthroughs. More victories.®

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Texas Oncology, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____

Print Name (Patient): _____ **DOB:** _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person Reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Texas Oncology Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge I have received a paper copy of the Texas Oncology Notice of Privacy Practices.

_____ **(Patient's Initials)**

Patient Name: _____ **Account #**_____
Please Print TXO will Complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Circle Preferred Language

AMERICAN SIGN LANGUAGE	FRENCH CANADIAN	LAO	SWAHILI
ARABIC	GERMAN	MAORI	SWEDISH
ARMENIAN	GREEK	MIEN	TAGALOG
BRAZILIAN PORTUGUESE	GUJARATI	NAVAJO	THAI
CHINESE	HEBREW	NORWEGIAN	TIGRINYA
CHINESE (CANTON)	HINDI	OROMO	TURKISH
CHINESE MANDARIN	HMONG	OTHER	UNDEFINED
CROATIAN	HUNGARIAN	PERSIAN	URDU
DANISH	INDIAN	POLISH	VIETNAMESE
ENGLISH	INDONESIAN	PORTUGUESE	VISAYAN
FARSI	ITALIAN	RUSSIAN	YIDDISH
FILIPINO	JAPANESE	SLOVAK	
FINNISH	KHMER	SOMALI	
FRENCH	KOREAN	SPANISH	

Circle Ethnicity HISPANIC OR LATINO NOT HISPANIC OR LATINO

Circle Preferred Method of Contact **H**ome phone **C**ell phone **W**ork phone
Email Mail Home Address

Phone number not previous provided _____ H C W (circle type)

Email address: _____

CIRCLE RACE

AFRICAN AMERICAN	HMONG	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	PACIFIC ISLANDER NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	POLYNESIAN NOS
CHAMORRAN	KOREAN	SAMOAN
CHINESE	LAOTIAN	TAHITIAN
FIJI ISLANDER	MELANESIAN NOS	THAI
FILIPINO	MICRONESIAN NOS	TONGAN
GUAMANIAN NOS	NATIVE AMERICAN	VIETNAMESE
HAWAIIAN	NEW GUINEAN	UNKNOWN
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	OTHER

Options/Values were selected by HITECH Act and Texas State Tumor Registry.