Broward Oncology Associates, P.A.
PATIENT INFORMATION

NAME:_____BIRTHDATE:_____AGE:_____

LOCAL ADDRESS (Street city state zip):

_____

_____

HOME TELEPHONE#_____CELL #_____

SOCIAL SECURITY #:_____-_____-_____SEX_____MARITAL STATUS____

WHAT IS YOUR HT? _____ WHAT IS YOUR WT? _____

EMPLOYER_____WORK#_____

SPOUSE'S NAME_____SPOUSE'S EMPLOYER_____

SPOUSE'S WORK# _____ PRIMARY LANGUAGE _____

NEXT OF KIN_____PHONE_____RELATIONSHIP_____

IN CASE OF EMERGENCY NOTIFY_____

PHONE #_____RELATIONSHIP _____

PRIMARY DOCTOR / REFERRING DOCTOR: (Please list each if not the same)

_____

_____

DOCTOR'S ADDRESS/PHONE_____

_____

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INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR BILL: _____

PRIMARY INSURANCE CO._____

NAME OF POLICY HOLDER_____

POLICY NUMBER_____GROUP NUMBER_____

OTHER INSURANCE COVERAGE (secondary) _____

NAME OF POLICY HOLDER _____

POLICY NUMBER_____GROUP NUMBER_____

****

I authorize the release of any medical information/records necessary to process your insurance claims and/or as requested by my doctor. I hereby assume financial liability for all services rendered.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis including treatment, payment, and other general health care concerns.

_____
__

_____
__

Patient Signature_____ Spouse's signature_____

Date_____

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******PLEASE TO COMPLETE THE OTHER SIDE******

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PATIENT INFO CONT'D _____ (name)

PERSONAL HISTORY: Please check if you have or had any of the following problem(s):

General --___ fevers ___ chills ___ sweats ___ anorexia ___ fatigue

___ malaise ___ weight loss ____ functional status ___ sleep > 8 hrs ___ sleep < 8 hr

Skin ___ rash ___ itching ___ prior melanoma ___ bleeding ___ NONE

Eyes ___ blurring ___ double vision ___ irritation ___ discharge

___ eye pain ___ cataracts ___ surgery ___ ___ vision loss ___ NONE

Breasts ___ mass (es) ___ pain ___ discharge ___ prior biopsy ___ NONE

DATE LAST MAMMOGRAM _____ _____ NOT DONE

PRIOR BREAST BIOPSY (S)? ---_____

Respiratory/cardiac ___ poor exercise tolerance ___ dyspnea ___ wheezing ___ cough

___ prior heart attack ___ sputum production ___ bloody cough ___ edema ___ chest pain ___ cyanosis ___ palpitations ___ pain in leg (s) ___ leg ulcers

___ vertigo ___ NONE

LAST CHEST X-RAY _____ _____ NOT DONE

Gastrointestinal ___ nausea ___ vomiting ___ diarrhea ___ constipation

___ change in bowel habits ___ abdominal pain ___ blood in stool

___ bright red blood per rectum ___ jaundice ___ prior kidney stones ___ NONE

LAST COLONOSCOPY _____ _____ NOT DONE

Genitourinary ___ painful urination ___ blood in urine ___ discharge ___ frequency

___ PAP smear (date done) _____

___ hesitancy ___ nocturia ___ incontinence ___ genital sores ___ impotence

___ kidney stones ____ sexual problems ___ NONE

___ still menstruating (if yes, # days) if no, date of last menses _____

Musculoskeletal ___ back pain ___ joint pain ___ joint swelling ___ muscle cramps

___ muscle weakness ___ stiffness ___ arthritis ___ gout _____ NONE

LAST BONE SCAN _____ LAST CT SCAN/MRI
_____

Neurologic ___ seizure ___ syncope ___ stroke ___ weakness ___ spasms

___ tremor ___ involuntary movements ___ abnormal gait ___ in coordination

___ pain ___ change in sensation ___ numbness of extremities ___ incontinence

___ NONE

Psychiatric ___ depression ___ anxiety ___ memory loss ___ mental disturbance

___ suicidal ideation ___ hallucinations ___ paranoia ___ NONE

Endocrine ___ cold and/or heat intolerance ___ excess or frequent urination ____ tremor

___ 10 lb weight gain or loss in the last month ___ thyroid disease ___ NONE

Hem/Onc ___ abnormal bruising ___ bleeding ___ enlarged lymph nodes

___ anemia ___ blood transfusions ___ prior cancer ___ prior blood clots? ___ NONE

LAST BLOOD TRANSFUSION --------_____

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Allergic reactions ___ hives ___ eczema ___ hay fever ___ persistent infections

___ NONE

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PATIENT INFO CONT'D _____ (name)

Personal History YES NO DATE

HIV _____ _____ _____

Tuberculosis _____ _____ _____

Pneumonia _____ _____ _____

Diabetes _____ _____ _____

High Blood Pressure _____ _____ _____

Blood Disease _____ _____ _____

Heart Disease _____ _____ _____

Liver Disease _____ _____ _____

Neurologic Disorders _____ _____ _____

MEDICATIONS - list all medications you are currently taking. Include ALL medications even those over the counter (OTC)

Drug Name (Generic/Brand) Dosage Frequency Status □ Chronic □ Acute □ DC'd □

□ Chronic □ Acute □ DC'd □

□ Chronic □ Acute □ DC'd □

□ Chronic □ Acute □ DC'd □

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□ Chronic □ Acute □ DC'd □

□ Chronic □ Acute □ DC'd □

ALLERGIES -

PAST MEDICAL HISTORY - Please provide a complete history including all illnesses, in juries, hospitalizations, and operations.

List all illnesses, injuries & operations (Please include date, hospital, treatment, and Physician)

Family History - Please list all blood relatives with their current health status and any illnesses they have had or now have

Blood Relatives Alive (age) State of health Illnesses Deceased (age) Cause of death

Father

Mother

Brother(s)

Sister(s)

Children

Social History - Please check the appropriate boxes and fill in the accurate amounts of standard portions

Smoking Alcohol Caffeine Aspirin Misc Drugs

*

Current □ Previous □ Beer/Week:_____ □ Coffee □Tea □ Cola #per day:_____ □ Vitamins

#packs per day ___ □ Liquor/Week: _____ □ other #of years: _____ □ Laxatives

#of years ___ Quit ___ □ Wine/Week: _____ Cups per day: ____ other: ____ □ Antacids

Other:
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