ONCOLOGY/ HEMATOLOGY DEPARTMENT

PATIENT REGISTRATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information:

Last Name	First Name	Middle Initial
Street Address	City/State/ Zip Code	Social Security
Phone Number	Date of Birth	
Cell Phone	Email	Marital Status

Emergency Contact/Phone #	Pharmacy Name & Phone #
It is ok to leave messages on your: Home Phone Yes No	Cell Phone Yes No
Please list the names of who we may disclose your medical information to should they make a request on your behalf (spouse, child, friend, caregiver)	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip Code	

Referred By:

Referred By:	Address	Phone #
Primary Care Physician	Address	Phone #

Insurance Information:

Name of First Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number	Local/Group Number		
Name of Secondary Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number	Local/ Group Number		

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security	Address	Zip Code
Home Number	Employer's Name	Work Number

I hereby authorize the Medical Oncology Clinic at Kona Community Hospital and its representatives to provide services to me and I authorize release of any medical and other pertinent information for the purpose of treatment and processing of my health insurance claims. I also authorize direct payment by my insurance to the Medical Oncology Clinic at Kona Community Hospital and understand that I am responsible for payment of all services, including deductible, co-payments and non-covered services. I understand and agree that I am responsible for any balance for services rendered regardless of my insurance status. I verify that the information provided here is accurate and I will notify the office immediately of any changes.

Signature of Patient or Authorized Representative	**Date**

KONA COMMUNITY HOSPITAL
Care You Can Count On

ONCOLOGY/ HEMATOLOGY DEPARTMENT

HEALTH HISTORY

Patient: ____ **Date of Birth:** ____________________

Please complete each line:

CONDITION	None	New	Chronic	CONDITION	None	New	Chronic
Fever				Difficulty Breathing			
Weight Loss				Abdominal Pain			
Weight Gain				Nausea			
Poor Appetite				Vomiting			
Night Sweats				Heartburn			
Chills				Diarrhea			
Fatigue				Constipation			
Change in Vision				Rectal Bleeding			
Ringing in Ears				Dark Colored Stools			
Mouth Sores				Change in Urination			
Pain in Mouth				Bone Pain			
Difficulty Swallowing				Back Pain			
New Dental Problems				Joint Pain			
Sore Throat				Muscle Pain			
Swollen Glands				Rash			
Chest Pain				Skin Peeling Hands/ Feet			
Palpitations				New Skin Growths/ Sores			
Swelling of Hands or Feet				Easy to Bruise			
Irregular/Pounding Pulse				Unusual Bleeding			
High Blood Pressure				General Weakness			
Cough				Headaches			
Cough with Phlegm				Numbness or Tingling			
Cough with Blood				Anxiety			
				Depression			
				Other Condition			

Pharmacy of Choice: ____
Lab Location of Choice:____
BP:__________ **Pulse:**______ **RR:**______ **O2:**______ **Temp:**______ **Ht:**________ **Wt:**_____

Have you had any of the following tests performed *since your last visit*?

TEST	Yes	No	Date	Where Performed?	Who Ordered the Test?
Blood Work					
Bone Scan					
PET Scan					
CT Scan					
MRI					
Ultrasound					

____ ________________________
Patient/Guardian Signature Date

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HEALTH HISTORY

Patient: ____ **Date of Birth:** ____________________

Tell us about your other medical problems and past surgeries:

Date	Condition or Surgery	Date	Condition or Surgery

Have you had any of the following tests performed?

Test	Yes	No	Date	Where?	Ordered by?
Recent Blood work					
Bone scan					
PET scan					
Recent CT scan					
Recent MRI					
Recent Sonogram (ultrasound)					

Family History:

Relationship	Age	Alive or Deceased	Any medical issues and cause of death if applicable
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			

Social History:

Do you smoke: No Quit Yes- How much? ______________________________ since what age: _________________________

How much alcohol do you drink (include beer & wine): _____________________________ How Often?____________________________

Do you have a: Living Will: No Yes Power of Attorney for healthcare: No Yes Who: _____________________________

Do you follow a special diet: No Yes Explain:____

Do you exercise regularly: No Yes Explain: ____

Highest level of Education: ____________________________ Past Occupation: ____

Are you exposed to any health hazards: No Yes Explain: ____

____ ___________________________________

Patient/Guardian Signature Date

Reviewed by: _________________ Date: _____________

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RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient:_______________________________________ **Date:** _________________________________

Date of Birth: _________________________________ **Physician:**_______________________________

Please circle YES for those conditions that apply to YOU and/or YOUR FAMILY (on both your mother's side (maternal) and your father's side (paternal). Then next to each statement please list the relationship to you and the age at diagnosis. You and the following family members should be considered: mother, father, sister, brother, children, paternal aunt/uncle, maternal aunt/uncle, first cousins, nieces, nephews, maternal grandmother/grandfather and paternal grandmother and grandfather.

Each statement should be answered individually, so you might list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes.

Breast & Ovarian Cancer

		Self	Family Member	Age at Diagnosis
Yes No	Breast Cancer before age 50			
Yes No	Ovarian Cancer			
Yes No	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Yes No	Male breast cancer			
Yes No	Triple negative breast cancer (ER-, PR-, HER2- pathology)			
Yes No	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Yes No	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family.			

Colon and Uterine Cancer

		Self	Family Member	Age at Diagnosis
Yes No	Uterine (endometrial) cancer before age 50			
Yes No	Colorectal cancer before age 50			
Yes No	Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer			
Yes No	Two or more Lynch syndrome cancers*			

Polyposis Syndrome

		Self	Family Member	Age at Diagnosis
Yes No	10 or more cumulative (lifetime) colorectal adenomas (colon polyps) in the family			

Melanoma

		Self	Family Member	Age at Diagnosis
Yes No	Two or more melanomas in an individual or family			
Yes No	Melanoma & pancreatic cancer in an individual or family			
Yes No	Have you or any family member been tested for hereditary risk of cancer? If yes, please explain			

*Lynch Syndrome related cancers include ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas

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MEDICATION LIST

Patient: ____ **DOB:** ____________________________________

Please list all known **ALLERGIES AND REACTIONS** (include medications, food, seasonal, etc.)

No allergies

Allergy to:	Type of Reaction:

Please list all **CURRENT** medications you are taking (include vitamins, supplements, nutritional and anything over the counter) **No medications**

Name of Medication	Dose	How many times a day do you take?	What do you take this medication for?

Completed by: _______________________________________ Date: ____________________________

Reviewed by: ____ Date: ____________________________

ONCOLOGY/ HEMATOLOGY DEPARTMENT

RELEASE OF MEDICATION HISTORY

Patient:_______________________________________ Date: __________________________________

Date of Birth: _________________________________ Social Security #:_________________________

To ensure your medications are up-to-date, and minimize the chance of duplication or causing potential interactions with other medications, please complete this authorization form. By doing so it will allow our office to utilize SureScripts to transmit prescriptions to your pharmacy. In addition, we will able to obtain your medication history from your pharmacy.

I, _________________________, authorize the Medical Oncology Clinic at Kona Community Hospital to obtain

information from my pharmacy __________________________________ regarding my medications.

This consent has been made freely and without coercion. I have been given the opportunity to have this consent explained to me and to ask questions pertaining to this release of my information. I understand that that those who receive this information will abide by HIPAA and maintaining confidential practices and not disclose this information further without my consent, unless permitted by federal or state law.

____ ____________________________
Signature of patient, parent or guardian Date

____
Print name of person who signed