KONA COMMUNITY HOSPITAL
Care You Can Count On

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	*Female*
Cell Phone	Email	Marital Status *Married*
Emergency Contact/Phone #	Pharmacy Name & Phone #	*slkdfjslkj*
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**

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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		*Alive*	
Father		*Alive*	
Sister(s)		*Alive*	
		Alive	
Brother(s)		*Alive*	
		Alive	
Daughter(s)		*Alive*	
		Alive	
Son(s)		*Alive*	
		Alive	

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: _____

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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