Lakewood Ranch ONCOLOGY Center

New Patient Questionnaire

Name: _____ Today's date: _____

Medical History…

Previous Cancer	Y / N	Glaucoma	Y / N	Crohn's Disease or Ulcerative Colitis	Y / N
High Blood Pressure	Y / N	Emphysema/COPD	Y / N	Kidney Loss, Dysfunction or Abnormality	Y / N
Heart Attack	Y / N	Diabetes	Y / N	Lupus/Scleroderma/Collagen Vascular Disease	Y / N
Pacemaker	Y / N	Diverticulitis	Y / N	Rheumatoid/Psoriatic Arthritis	Y / N
Stroke	Y / N				

Previous Radiation Therapy Y / N If Yes, To What Part of The Body? _____

Facility Name: _____ Dates: _____

Previous or Current Chemotherapy Y / N If Yes, Facility Name _____ Dates: _____

Previous Surgeries:

Type of Operation	Approximate Date	Type of Operation	Approximate Date
_____		_____	
_____		_____	
_____		_____	

Other Illnesses/Hospitalizations _____

Prostate Surgery (Transurethral Resection of Prostate "TURP") Y/N If Yes, When? _____ Date of Last Colonoscopy _____

Medications/Supplements… *(List ALL Medications/Vitamins & Supplements You Are Currently Taking)*

Medication	Dose	Dose/Day	Medication	Dose	Dose/Day
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Medication Allergies… _____ None

Medication _____ Reaction _____

Medication _____ Reaction _____

Family History of Cancer…

	Type/Location of Cancer	Age At Diagnosis		Type/Location of Cancer	Age At Diagnosis
Father	_____		Brother/Sister	_____	
Mother	_____		Brother/Sister	_____	

Social History…

Do You Drink Alcohol? Y / N If Yes, Average Number of Drinks Per Day _____

Have You Ever Smoked Cigarettes? Y / N If Yes, Year You Began Smoking _____ Year Stopped _____

Average # of Packs Smoked Per Day _____ List Other Tobacco Products Used _____

Current Occupation _____ # Years _____

Previous Occupation _____ # Years _____

Review of Symptoms… *Have You Developed Any of These Symptoms In The Past Year?*

Weight Loss	Y / N	Fatigue	Y / N	Cough	Y / N	Weakness	Y / N
Decreased Appetite	Y / N	Fever	Y / N	Short of Breath	Y / N	Numbness/Tingling	Y / N
Nausea	Y / N	Bone Pain	Y / N	Chest Pain	Y / N	Memory Problems	Y / N
Diarrhea	Y / N	Skin Rashes	Y / N	Depression	Y / N	Vision/Hearing Changes	Y / N
Bleeding Problems	Y / N	Swollen Glands	Y / N	Headaches	Y / N	Change In Urination	Y / N

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International Prostate Symptom Score (IPSS)

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

In The Past Month:	Not At All	Less Than 1 in 5 Times	Less Than Half The Time	About Half The Time	More Than Half The Time	Almost Always	Your Score
1. Incomplete Emptying… How often have you had a sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency… How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency… How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency… How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream… How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining… How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	1 Time	2 Times	3 Times	4 Times	5 Times	
7. Nocturia… How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total IPSS Score:							

Quality of Life Due To Urinary Symptoms…	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Urine Leakage… (Incontinence)	No Leakage	Mild (A few drops a day, no pad use)	Mild (More than a few drops a day, 1 – 2 pad/day)	Moderate (3 or more pads per day)	Severe Leakage Problems
Circle One	0	1	2	3	4

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Sexual Health Inventory

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

Each question has several possible responses. Circle the number of the response that best describes your own situation.
Please be sure that you select one and only one response for each question.

Current Status…

1. How do you rate your *confidence* that you could achieve and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, *how often* were your erections hard enough for penetration (entering your partner)?

No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
0	1	2	3	4	5

3. During sexual intercourse, *how often* were you able to maintain your erection after you had penetrated (entered) your partner?

Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
0	1	2	3	4	5

4. During sexual intercourse, *how difficult* was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, *how often* was it satisfactory to you?

Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
0	1	2	3	4	5

Score: _____ (Add the numbers corresponding to questions 1 – 5)

Bowel Health Inventory…

Circle One ***(If you need further clarification on what grade to circle, please don't hesitate to ask the nurse or doctor)***

Grade	*Adverse Event*
0	No problems, no rectal bleeding, no discharge, less the 5 bowel movements a day.
1	Mild diarrhea and/or mild cramping and/or bowel movements more than 5 times daily and/or slight rectal discharge or bleeding.
2	Moderate diarrhea and colic and/or bowel movements more than 5 times daily and/or excessive rectal mucus and/or intermittent bleeding.
3	Obstruction or bleeding, requiring surgery.
4	Necrosis / Perforation / Fistula

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Release of Medical Records

Date:_____

I request that:

Physician's Name _____

Address _____

City, Sate, Zip _____

Telephone # _____

Fax # _____

Release any and all medical records and send them to:

Physician's Name _____

Address _____

City, Sate, Zip _____

Telephone # _____

Fax # _____

This Information Can Vary Based On Individual Circumstance
Leave This Section Blank And The Oncology Office Will Fill It Out

I understand that these records contain administrative and/or billing information, and I give my permission for the release of that information.

I also give my permission for this material to be transmitted by telefax. I understand that it is my responsibility to provide this office with an accurate fax number if records are to be faxed. I understand that faxing records may result in transmission to the wrong fax number. I accept the risk of mis-transmission if my records are faxed and relieve this office and its agents and employees of any liability for mis-transmission by fax.

I understand that this record may contain information about HIV test results. I give permission for release of this information.

This release is effective until and unless revoked in writing.

Signature_____

PLEASE PRINT:

Name _____

Date of Birth _____

Social Security # _____

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Lakewood Ranch ONCOLOGY Center

Notice of Private Practices For Personal Health Information

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Lakewood Ranch Radiation Oncology Center, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a referring or specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about our appointments. If you are not home, we may leave information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you or fax to a secure HIPPA compliance fax number.

You have the right to see and receive a copy of your health information, with few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC 20201. You will not be retaliated for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Aimee Stratford, at 941-907-9053.

This notice goes into effect as of April 14, 2003.

Please list any other persons that we may discuss your medical condition with, i.e. family members, guardians, etc.

_____, _____, _____

_____, _____, _____

Acknowledgement…

I have received a copy of the Lakewood Ranch Radiation Oncology Center Notice of Privacy Practices: Date_____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

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