Oncology & Hematology
Specialist, P.A.

Mountain Lakes Office
333 Route 46 West Mountain Lakes
New Jersey, 07046
973.316.1701

Morristown Office
Simon Cancer Center,
Morristown Memorial Hospital
100 Madison Avenue, Suite 3402
Morristown, NJ 07962
973.267.9543

Today's date: PCP:

Patient Information

Last name: ☐ Mr. ☐ Miss Gender: ☐ Male ☐ Female

First name: ☐ Mrs. ☐ Ms. Age:

Middle name: Birth date:

Is this your legal name? ◯ Yes ◯ No Marital Status:

If not, what is your legal name? Social Security No:

(Former name): Home Phone No:

Street Address: City:

P.O. Box: ZIP Code: State:

Occupation: Employer: Employer Phone:

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr.

☐ Insurance Plan ☐ Yellow Pages ☐ Family ☐ Hospital ☐ Friend ☐ Close to home/work ☐ Other

Other family members seen here:

Your Local Pharmacy Town: Phone:

Insurance Information **(Please give your insurance card to the receptionist.)**

Person responsible for bill: Birth date:

Address (if different): Home Phone No:

Is this person a patient here? ◯ Yes ◯ No

Occupation: Employer:

Employer Address: Employer Phone:

Is this patient covered by insurance: ◯ Yes ◯ No

Please indicate primary insurance:

Subscriber's name: Birth date:

Subscriber's S.S. no.: Group No: Policy No: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):

Subscriber's name: Group No: Policy No:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

In Case of Emergency

Name of local friend or relative: Relationship to patient:

Home Phone No: Work Phone No:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Oncology & Hematology Specialists, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian Signature Date:

Oncology & Hematology Specialists, P.A.

Original Date:

Dates Revised:

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: Gender: ☐ Male ☐ Female

Marital Status: Birth date:

Previous or Referring Doctor: Date of Last Physical Exam:

Personal Health History

Childhood Illness: ☐ Measles ☐ Polio ☐ Mumps ☐ Rubella ☐ Rheumatic Fever ☐ Chickenpox

Immunizations and dates:

☐ Tetanus ☐ Pneumonia

☐ Hepatitis ☐ Chickenpox

☐ Influenza ☐ MMR (Measles, Mumps, Rubella)

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ◯ Yes ◯ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

Health Habits and Personal Safety

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting? ◯ Yes ◯ No

If yes, are you on a physician prescribed medical diet? ◯ Yes ◯ No

# of meals you eat in an average day? _____

Rank salt intake ☐ Hi ☐ Medium ☐ Low

Rank fat intake ☐ Hi ☐ Medium ☐ Low

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola

Alcohol

Do you drink alcohol? ◯ Yes ◯ No

If yes, what kind? _____

How many drinks per week? _____

Are you concerned about the amount you drink? ◯ Yes ◯ No

Have you considered stopping? ◯ Yes ◯ No

Have you ever experienced blackouts? ◯ Yes ◯ No

Are you prone to "binge" drinking? ◯ Yes ◯ No

Do you drive after drinking? ◯ Yes ◯ No

Tobacco

Do you use tobacco? ◯ Yes ◯ No

☐ Cigarettes – pks./day

☐ Chew - #/day

☐ Pipe - #/day

☐ Cigars - #/day

☐ # of years

☐ Or year quit

Sex

Are you sexually active? ◯ Yes ◯ No

If yes, are you trying for a pregnancy? ◯ Yes ◯ No

If not trying for a pregnancy list contraceptive or barrier method used:

Any discomfort with intercourse? ◯ Yes ◯ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ◯ Yes ◯ No

Personal Safety

Do you live alone? ◯ Yes ◯ No

Do you have frequent falls? ◯ Yes ◯ No

Do you have vision or hearing loss? ◯ Yes ◯ No

Do you have an Advance Directive or Living Will? ◯ Yes ◯ No

Would you like information on the preparation of these? ◯ Yes ◯ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ◯ Yes ◯ No

MENTAL HEALTH

Is stress a major problem for you? ◯ Yes ◯ No

Do you feel depressed? ◯ Yes ◯ No

Do you panic when stressed? ◯ Yes ◯ No

Do you have problems with eating or your appetite? ◯ Yes ◯ No

Do you cry frequently? ◯ Yes ◯ No

Have you ever attempted suicide? ◯ Yes ◯ No

Have you ever seriously thought about hurting yourself? ◯ Yes ◯ No

Do you have trouble sleeping? ◯ Yes ◯ No

Have you ever been to a counselor? ◯ Yes ◯ No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every ____ days

Heavy periods, irregularity, spotting, pain, or discharge? ◯ Yes ◯ No

Number of pregnancies ____ number of live births ____

Are you pregnant or breast-feeding? ◯ Yes ◯ No

Have you had a D&C, hysterectomy, or Cesarean? ◯ Yes ◯ No

Any urinary tract, bladder, or kidney infections within the last year? ◯ Yes ◯ No

Any blood in your urine? ◯ Yes ◯ No

Any problems with control of urination? ◯ Yes ◯ No

Any hot flashes or sweating at night? ◯ Yes ◯ No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ◯ Yes ◯ No

Any blood in your urine? ◯ Yes ◯ No

Any problems with control of urination? ◯ Yes ◯ No

MEN ONLY

Do you usually get up to urinate during the night? ◯ Yes ◯ No

If yes, # of times ____

Do you feel pain or burning with urination? ◯ Yes ◯ No

Any blood in your urine? ◯ Yes ◯ No

Do you feel burning discharge from penis? ◯ Yes ◯ No

Has the force of your urination decreased? ◯ Yes ◯ No

Have you had any kidney, bladder, or prostate infections within the last 12 months? ◯ Yes ◯ No

Do you have any problems emptying your bladder completely? ◯ Yes ◯ No

Any difficulty with erection or ejaculation? ◯ Yes ◯ No

Any testicle pain or swelling? ◯ Yes ◯ No

Date of last prostate and rectal exam? ◯ Yes ◯ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- ☐ Skin
- ☐ Head/Neck
- ☐ Ears
- ☐ Nose
- ☐ Throat
- ☐ Lungs
- ☐ Chest/Heart
- ☐ Back
- ☐ Intestinal
- ☐ Bladder
- ☐ Bowel
- ☐ Circulation
- ☐ Recent changes in: ____
- ☐ Weight
- ☐ Energy level
- ☐ Ability to sleep
- ☐ Other pain/discomfort

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Gender: ☐ Male ☐ Female Age: _____

Health Care Provider: _____ Date of Birth: _____

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, cousins, great-grandparents, nieces, nephews, half-siblings, grandchildren

CANCER	You	Age of Diagnosis	Siblings/Children	Age of Diagnosis	Mother's Side	Age of Diagnosis	Father's Side	Age of Diagnosis
For example: Colon/rectal cancer	*None*	-----	*Brother*	*36 yrs*	*Aunt Cousin*	*44 yrs 58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast Cancer *(Male or Female)*								
Ovarian Cancer *(Peritoneal/Fallopian tube)*								
Breast cancer in both breasts OR multiple primary breast cancers								
Male Breast Cancer								
Pancreatic cancer or aggressive prostate cancer* *(*Gleason Score≥7)*								
Are you of Ashkenazi Jewish descent?	◯ Yes	◯ No						
COLON AND ENDOMETRIAL CANCER								
Endometrial *(Uterine)* cancer								
Colon/rectal cancer								
Ovarian cancer *(Peritoneal/Fallopian tube)*								
Stomach *(Gastric)*/Small bowel cancer								
Kidney, urinary tract, biliary tract cancer								
Pancreatic cancer								
Brain cancer								
Sebaceous adenomas								
10 or more lifetime colon/rectal polyps *(specify #)*								

MELANOMA

Melanoma								
Pancreatic cancer								

OTHER CANCER *(specify cancer type)*

Have your or anyone in your family had genetic testing for a hereditary cancer syndrome? ◯ Yes ◯ No

If Yes, Who? | What gene(s)? | What was the result?

Patient's Signature: Date:

Health Care Provider's Signature: Date:

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Patient offered hereditary cancer genetic testing? ◯ YES ◯ NO ◯ ACCEPTED ◯ DECLINED

If Yes, which test? ◯ BRAC*Analysis*® with Myriad myRisk® ◯ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

◯ COLARIS®PLUS with Myriad myRisk ◯ COLARIS *AP*®PLUS with Myriad myRisk ◯ Single Site Testing ◯ Myriad myRisk Update

◯ Other:

Follow-up appointment scheduled: ◯ Yes ◯ No Date of next appointment:

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the health insurance portability & Accountability Act of 1988 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been advised of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and that a copy of these practices was made available to me. I understand that this organization has the right to change or update its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment and payment of health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if agreed, this organization must be bound to abide such restrictions.

Patient Name		Signature	
Other		Relationship to Patient	
Date			

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I attempted to obtain the patient's/designee's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date		Initials		Reason: unable to sign		Refused to sign	

ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.

HIPAA CONSENT

Oncology & Hematology Specialists (OHS) requires written authorization to discuss your care with family, friends or others.

Patient Name

Date of Birth

Street Address

City/State/ZIP

The following names listed are those that I give Oncology & Hematology Specialists authorization to discuss my care:

	Relationship		Phone Number	
	Relationship		Phone Number	
	Relationship		Phone Number	

Or, **DO NOT PROVIDE** health information to anyone but me.

Do you have a Medical Power of Attorney ◯ Yes ◯ No

If yes: Name

	Relationship		Contact Number	

This authorization will remain in effect until I have completed and signed an updated authorization or I provide a written notice of revocation to Oncology & Hematology Specialists.

If I have questions about disclosure of my health information, I can contact OHS at 973 316-1701 or email via the patient portal.

Patient/Legal Representative **Date**

I need not sign this form in order to assure treatment.
(To be completed if patient refuses to sign acknowledgement)

Date Name of person providing notice

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner for appointments and test results:

Check all that apply

Home/Cell Number _____ Work Number _____

- ☐ Leave message with appointment date and time
- ☐ Leave message with test results
- ☐ Leave message with dietary restrictions for scheduled tests
- ☐ Leave a call back number only
- ☐ Do not leave message

OHS may leave PHI on my voice mail/answering machine	◯ Yes	◯ No
OHS may leave PHI with an adult who answers your home phone	◯ Yes	◯ No
If you use a transportation service to bring you to appointments/treatments, may we release limited PHI such as end of treatment time to the driver/transportation company?	◯ Yes	◯ No

_____ _____

Patient/Legal Representative **Date**