Florida Oncology Tavares
RADIATION TREATMENT CENTER

NEW PATIENT FORMS

(Please Print. Thank You.)

Patient Name: _____ **Date of birth**: _____

Address: _____ **Social Security Number**: _____

City: _____ **State**: _____ **Zip Code**: _____

Secondary Address: _____

City: _____ **State**: _____ **Zip Code**:_____

Home Phone: _____ **Cell Phone**: _____

May we leave a message on your answering machine / voicemail? ☐ **Yes** ☐ **No**

Email Address: _____

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American

☐ Asian/Pacific Islander ☐ Other

Pharmacy: _____
Name Address City State

EMERGENCY CONTACT (PARENT/GUARDIAN IF PATIENT IS A MINOR)

Name: _____ **Relationship**: _____

Home Phone: _____ **Cell Phone**:_____

Power of Attorney (if applicable): _____**Relation to You**: _____

Living Will: ☐**Yes** ☐**No** *Please provide a copy for your record

I certify that the information I will give today is to the best of my ability and as fully accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
PATIENT LEGAL GUARDIAN/REPRESNTATIVE OR PARENT **DATE**

Primary Care Physician: _____ **Phone #**: _____

Referring Physician (if different):_____ **Phone #**: _____

Please list any additional Physicians you see: (Include Phone #):

_____ **Phone #:**_____

_____ **Phone #:**_____

_____ **Phone #:**_____

_____ **Phone #:**_____

_____ **Phone #:**_____

Insurance

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy holder's Date of Birth: _____**Policy holder's SS#:** _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone number: _____

Does plan have prescription coverage? □ Yes □ No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____

Policy holder's Date of Birth: _____ **Policy holder's SS #:** _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employee phone number: _____

Does plan have prescription coverage? □ Yes □ No

REASON FOR THIS VISIT: _____

_____

CANCER HISTORY:

Type: _____ Date Diagnosed: _____

Treatment: (Type, Date, location of treatment, and Physician)

Previous Radiation Therapy: _____

Previous Chemotherapy: _____

Previous Surgery: _____

MEDICAL HISTORY:

(Check the items that apply to you, currently or in the past)

- ☐ None
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Disorder
- ☐ Frequent infections
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Attack-MI
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Heartburn / Reflux
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Peripheral Vascular Disease
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia/Bronchitis
- ☐ TB (Tuberculosis)
- ☐ Sleep Apnea
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Stomach Ulcers
- ☐ GERD/Heartburn
- ☐ Hiatal Hernia
- ☐ Gallstones
- ☐ Cirrhosis of Liver
- ☐ Hepatitis A /B / C
- ☐ Pancreatitis
- ☐ Kidney Stone
- ☐ Kidney Disease/Failure
- ☐ Enlarged Prostate
- ☐ Lupus-Autoimmune
- ☐ Reynaud's Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Chronic Back Pain
- ☐ Osteoporosis
- ☐ Fracture
- ☐ Stroke
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Paralysis
- ☐ Seizures
- ☐ Migraines
- ☐ Shingles
- ☐ Glaucoma/Cataracts
- ☐ Hearing Loss
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Anxiety
- ☐ Depression
- ☐ Drug Use
- ☐ Problems w/Anesthesia
- ☐ Freq. Urinary Tract InfectionS

Health Maintenance:
Sigmoidoscopy / Colonoscopy: ☐ Yes ☐ No Date: _____ Findings: _____
Last Mammogram Date: _____ Last Bone Density Date: _____ Last Pelvic Exam Date: _____
Influenza (Flu) Shot Date: _____ Pneumococcal Shot Date: _____
Last Shingles Shot Date: _____ Last EGD Date: _____

PAST SURGICAL HISTORY:

(Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Bypass	Date:_____	Knee Replacement	Date:_____
Angioplasty	Date:_____	Rotator Cuff Repair	Date:_____
Pacemaker	Date:_____	Cataract	Date:_____
Cardiac Valve surgery	Date:_____	Gallbladder surgery	Date:_____
Hemorrhoidectomy	Date:_____	Hysterectomy	Date:_____
TURP	Date:_____	Prostatectomy	Date:_____
Hernia Repair	Date:_____	Appendectomy	Date:_____
Tonsillectomy	Date:_____	Hip Replacement	Date:_____
Mastectomy	Date:_____	Lumpectomy	Date:_____

Other Operations: _____

MEDICATION LIST:

Your treatment can be affected by any medication that you take. It is important that your physician has updated and correct information.

List **ALL** medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician

ALLERGIES: List all medication allergies

Medication: _____ Reaction: _____

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Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye / IV Contrast ☐ Eggs ☐ Peanuts

Other: _____

Type of reaction: _____

FAMILY MEDICAL HISTORY:
Indicate any family members with cancer, blood disease or other disease

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No
Please list: _____

SOCIAL HISTORY:

Birth City: _____ Birth State: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Children: ☐ Yes ☐ No Number of Children: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Student ☐Retired **Retired Date**: _____

Occupation (Former if Retired):_____

Employer (Former if Retired): _____

Military History:
Have you ever served in the military? ☐ Yes ☐ No

If yes, service branch and duties: _____

Years in service: _____

Agent Orange Exposure ☐ Yes ☐ No

Tobacco Use: (Present &/or Past)
☐ **Never Smoked**
☐ **Quit Smoking When? _____ How many years did you smoke?** ____yr(s) **How many packs?** ___/day
☐ **Currently Smoke** ☐ **Cigarettes** ☐ **Pipe** ☐**Cigars** ☐ **Chewing Tobacco**

Alcohol Use:
☐ **Non Drinker**
☐ **Beer** number of bottles _____ per ☐ **Day** ☐ **Week** ☐ **Month**
☐ **Wine** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**
☐ **Liquor** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**

REVIEW OF SYSTEMS:
(Please check any **current** symptoms you have.)

General:
☐ Weight loss
How much_____
Over what time period _____
☐ Fevers
Max temp _____
☐ Chills
☐ Night Sweats
☐ Fatigue

Eyes:
☐ Wear Glasses/Contact Lenses
☐ Blurred Vision
☐ Double Vision

Ears, Nose, Throat:
☐ Hard of hearing or deaf
☐ Ringing in ears
☐ Enlarged lymph nodes
☐ Chronic sinus problems
☐ Sore throat
☐ Mouth pain/sores

Changes/Difficulty In:
☐ Taste
☐ Smell
☐ Voice

Cardiovascular:
☐ Chest pain/Angina Pectoris
☐ Palpitations/heart murmur
☐ Irregular heart beat pressure

Respiratory:
☐ Chronic or Frequent Cough
☐ Bloody Sputum
☐ Shortness of breath

Gastrointestinal:
☐ Difficult or painful swallowing
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Lump or sensation in throat
☐ Food Sticking
☐ Bloating
☐ Belching
☐ Diarrhea
☐ Constipation
☐ Rectal Bleeding
☐ Black or tarry stools
☐ Blood in stool
☐ Excessive rectal gas/flatus
☐ Loss of stool/fecal accident
☐ Poor appetite
☐ Jaundice

Genitourinary:
☐ Kidney Stones
☐Pelvic Pain
☐ Incontinence
☐ Burning or pain in urination
☐ Blood in urine
☐ Difficult urination
☐ Men: Prostate problems

Musculoskeletal:
☐ Joint Pain/Arthritis
☐ Muscle or joint weakness
☐ Back pain
☐ Bone pain
☐ Muscle aches

Neurologic:
☐ Numbness, tingling
☐ Arm or leg weakness
☐ Light-headed, dizzy, fainting spells
☐ Headache

Skin:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose vein
☐ Skin Cancer

Psychiatric:
☐ Anxiety/Agitation
☐ Depression
☐ Crying for no reason
☐ Insomnia
☐ Alcoholism
☐ Drug Problem (Now/Past)

Hematologic:
☐ Easy bruising
☐ Gum or nose bleeding
☐ Blood transfusion in the past

Allergies/Immunology:
☐ History of chronic infections
☐ History of allergies

Endocrine:
☐ Heat or cold intolerance
☐ Excessive skin dryness
☐ Excessive thirst or urination
☐ Weight problem
☐ Hot flashes

Breast:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose veins
☐ Skin cancer

Gynecologic:
Age at start of menses _____
Last menstrual period _____
☐ Breast pain/lump
☐ Breast discharge or rash
☐ Vaginal discharge
☐ Menstrual irregularity
☐ Hormone replacement therapy?
Use? _____
If Yes, How long? _____