Welcome New Patient

A blood disorder or cancer diagnosis can be a scary and uncertain time in your life, but confidence in your care does not have to be. At Comprehensive Blood and Cancer Center (CBCC) our health professionals will educate and equip you with all of the information you need to help you make informed decisions about your care.

CBCC provides patients with access to state-of-the-art technology, elite medical experts, resources, and treatment options using the most advanced diagnostic tools, including genetic and genomic testing. We work with you to tailor a treatment plan specific to your needs. Our Patient Navigators act as a support system to walk you through every step of your journey. We also offer financial assistance through local and regional organizations so you can devote all your time and energy into getting well.

CBCC's diverse team of physicians and practitioners offers a comprehensive variety of services, from cancer screenings, to diagnostics, and clinical research. Additionally, we offer numerous non-cancer-related medical services including blood disorders, pain management, dermatology, and integrated oncology to support all of you: mind, body and spirit. Our highly-skilled teams bring their expertise from different fields to rigorously review your case and work with you to determine your best options for care. With accreditations from the American College of Radiology and the National Accreditation Program for Breast Cancer, CBCC will provide you with a level of care unmatched by any other cancer center in the region.

Our healthcare teams will be with you every step of the way to provide you with the knowledge, resources and confidence that you are receiving the best medical care.

Sincerely,
Comprehensive Blood & Cancer Center

New Patient Packet

Directions to CBCC and Campus Map	*page* **3**
Attendance Policy	*page* **4**
Code of Conduct	*page* **5**
Prescription Refill Policy	*page* **6**
Patient Information Form	*page* **7**
Request for Release of Medical Records & Pathology Material	*page* **8**
Consent to Obtain Patient Medication History	*page* **9**
Release of Patient Medical Information	*page* **10**
HIPAA Notice of Privacy Practices (NPP)	*page* **11**
Patient Financial Responsibility Assignment of Benefits	*page* **13**
CBCC Payment Policies	*page* **14**
Financial Liason Letter	*page* **15**
Patient Health and Medical History Questionnaire	*page* **Q-1**

We understand that having an illness is difficult for you and your family. Our physicians and staff are sensitive to this and are dedicated to helping you. When you arrive at CBCC, please sign-in with the receptionist. If for some reason you are unable to keep your scheduled appointment, please call as soon as possible to reschedule. This will allow us to use your time slot for another patient, and will permit you to receive the next earliest appointment time possible.

What you need to bring:

a. Please complete the required forms found in our packet and bring them with you to your scheduled appointment.
b. Advanced Directive; Please bring a copy for us to place in your medical record.
c. List of medications with dose and frequency and start date.
d. Photo ID, such as a driver's license.
e. List of allergies (med/food), reaction and date of first occurrence.
f. Medical insurance card(s).

If you have any questions, please call us at: **(661) 322-2206**.

Directions to CBCC

We are located on the south side of Truxtun Avenue across the street from the Truxtun Lake, between Mohawk and Coffee Road.

From Highway 99 southbound, take the California Avenue exit, turn left on California, then left on Oak Street, go to Truxtun Avenue (first stop light), turn left and go about 3 miles. Turn left on Truxtun Plaza West and turn right into the first parking lot and continue back to the one story building.

From Highway 99 northbound, take the California Avenue Exit, turn right on California, then left on Oak Street, go to Truxtun Avenue (first stop light), turn left and go about three miles, we are on the left (south) side.

A Building A

Breast Health Center **(A3 Entrance)**
Dignity Health Infusion Center
Dispensary
Health & Wellness Café **(A1 Entrance)**
Lab
Mammography **(A5 Entrance)**
Medical Assistants
Medical Records
Receptionist
RNs, PAs, Drs
Scheduling
Surgery Center **(A5 Entrance)**

B Building B

First Floor:
Dermatology & Laser Center

Second Floor:
Business Billing
Global Research
Human Resources
Quality Assurance

C Building C

Cyberknife®

CBCC COMPREHENSIVE BLOOD & CANCER CENTER
Outsmarting Cancer™

(661) 322-2206 *main* | (661) 322-7027 *fax* | 6501 Truxtun Avenue, Bakersfield, CA 93309 | www.cbccusa.com
A Jonsson Comprehensive Cancer Center TRIO-US Site

Rev. 06.11.25

Attendance Policy

CBCC strives to make everyone's visit comfortable and timely while offering the best quality of care. In an effort to respect everyone's schedule and maximize the time our patients spend with their provider/medical care team during their visits, our attendance policy is as follows:

1. Please arrive 15-minutes before your first scheduled appointment to allow ample time for check-in.
   New Patients: CBCC requires all first-time patients to arrive at least 30-minutes before your first appointment time in order to ensure that we have all necessary paperwork and documents on file during your new-patient appointment.

2. **Patients who arrive late *(less than 15-minutes BEFORE the scheduled appointment time)* may be required to reschedule**. Patients with three tardies and/or missed appointments may result in a full discharge from the clinic.

3. We understand that life happens. We require that all appointments are confirmed, canceled, or rescheduled at least 24 business hours before your appointment.

4. Occasionally, patients require unexpected, immediate attention throughout treatment. In such situations, please call us at **(661) 322-2206** before coming to the facility in an effort to expedite the scheduling of your visit and limit your wait time to the best of our ability. ***CBCC does not offer walk-in appointments***.

5. **Visitors**: Space at CBCC is limited. Please only bring 1 (one) visitor with you to your appointment.
   Radiation Exposure Notice: For safety reasons, CBCC prohibits visitors who are pregnant and/or children under 16 years old.

We look forward to serving you and making your visit a pleasant one.

Your signature below indicates that you have read and agree to CBCC's Attendance Policy.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Code of Conduct

CBCC is committed to ensuring a safe, secure and respectful environment for everyone – patients, visitors, physicians, providers, healthcare teams and employees.

It is our expectation that all individuals will demonstrate civil and respectful behavior while on our premises.

We expressly prohibit:

- Abusive language including threats and slurs
- Sexual harassment
- Physical assault
- Weapons

To maintain a safe, secure and respectful environment for all, we reserve the right to take appropriate measures to address abusive, disruptive, inappropriate or aggressive behavior.

Your signature below indicates that you have read and agree to CBCC's Code of Conduct.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Prescription Refill Policy

- To ***request a refill*** call your pharmacy 72 hours prior to your last dose.
- For outside prescriptions (prescriptions not filled by CBCC) your pharmacy will send an electronic request to your provider.
- ***Please do not*** call CBCC, your physician's office will respond to the pharmacy request.
- To change a prescription call CBCC and ask for your physician's office. Do ***not*** call your pharmacy.
- Leave a message with your name, date of birth and prescription request.
- If your request is approved the prescription will be sent to your pharmacy. If it is ***not*** approved your physician's office will call you.
- Messages are checked every two hours –***Please do not*** call back to inquire about your prescription.

DEA Schedule II Drugs

Codeine	Oxycodone	Fentanyl	Morphine
MSContin	Thylox	Percocet	Roxanol
Seconal	Dilaudid	Hydrocodone	
Demerol	Oxycontin	Methadone	

- ***Must be sent via secure electronic prescription.*** Limited to a 30 day supply with no refills.
- To request another 30 day supply or to request a change in your medication call CBCC ***at least 72 hours prior to your last dose*** and ask for your physician's office.
- Leave a message with your name, date of birth and prescription request.
- Call Monday and your pharmacy should receive by Thursday.
- Call Tuesday and your pharmacy should receive by Friday.
- Call Wednesday and your pharmacy should receive by Monday.
- Call Thursday and your pharmacy should receive by Tuesday.
- Call Friday and your pharmacy should receive by Wednesday.
- If your request is ***not*** approved, your physician's office will call you.

Requesting Medical Records, CD's, or Physicians Letters

For any medical records, imaging CD's or physician letters please call **(661) 322-2206**. Please allow up to 48 hours for your request to be processed. In the event that your request will take longer, CBCC will notify you.

We understand that sometimes these are needed urgently and in these situations we will do our best to accommodate your request.

Patient Information Form

First Name: _____

Last Name: _____

Sex: ☐ Male ☐ Female

Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Employer: _____

Occupation: _____

Work Phone: _____

Language(s) Spoken: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic
☐ Native Hawaiian ☐ Pacific Islander
☐ Native American or Alaskan Native
☐ Decline to Answer
☐ Other: _____

Spouse or Responsible Party:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Preferred Method of Contact:

☐ Phone ☐ Text ☐ Email

By agreeing to receive text messages from CBCC, you acknowledge that standard text messaging rates from your wireless carrier may apply.

Person to Contact in Case of Emergency:

Permission to discuss my treatment, diagnostic tests and medical condition:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Relationship to Patient: _____

Please bring your insurance card(s) and your prescription card with you to present to the receptionist when you arrive for your appointment.

Prescription Drugs: To better meet our patients' needs we can dispense some of the prescriptions as prescribed by our physician(s) here on our campus. We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and that you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 or www.mbc.ca.gov

Date: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Request for Release of Medical Records & Pathology Material

URGENT

Physician/Hospital Name: _____

_____

Address: _____

_____

_____

Dates of Hospitalization: _____ thru _____

Date: _____

Patient Name: _____

Date of Birth: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

I hereby request any and all of the following medical records in your possession:

- ☐ Imaging Reports
- ☐ Laboratory & Pathology Results
- ☐ Pathology Material
- ☐ Physicians Office Records
- ☐ Hospital Records
- ☐ HIV Test Results
- ☐ Mental Health Records Protected by Lanterman-Petris –Short Act
- ☐ Other: _____

The authorization is effective now and will remain in effect until one year from date signed.

If not signed by patient, please indicate the relationship:

- ☐ Parent or guardian of a minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of a deceased patient
- ☐ Spouse or person financially responsible –where information is solely for the purpose of processing an application for dependent health care coverage

For mental health records only:

Physician Signature: _____

Date: _____

To be released and faxed to:

Comprehensive Blood & Cancer Center
6501 Truxtun Avenue
Bakersfield, CA 93309
Fax: **(661) 322-7027**

Consent to Obtain Patient Medication History

Your patient medication history is an important part of helping our providers treat your symptoms and/or illness properly and avoiding potentially dangerous drug interactions. Your medication history has been compiled from a variety of sources including, but not limited to, pharmacies, insurance companies and other healthcare providers. This information is stored in the electronic medical records (EHR/EMR) and is considered part of your medical record.

It is important that you discuss your medication history with your provider. While most of your medication history will be available, there are instances where items may not be available including, but not limited to, drugs that were purchased without using insurance, over-the-counter drugs, supplements and pharmacies that do not make medication history available.

By signing below I hereby give my permission to allow CBCC and its provider(s) to obtain my medication history. I understand that I am giving my consent for CBCC to collect and giving my pharmacy, insurance plans and other entities permission to disclose information about my medication history which may include, but not be limited to, medications to treat AIDS/HIV and medications prescribed to treat mental health issues such as depression.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Release of Patient Medical Information

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my treatment, diagnostic tests, medical condition with the following individuals:

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my Mental Health Records protected by Lanterman-Petris –Short Act with the following individuals:

_____ *(Initial)* Do not release medical information.

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone:

Release Information to:

Name: _____

Relationship: _____

Phone:

This is an indefinite consent form unless otherwise specified.

I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

HIPAA Notice of Privacy Practices (NPP)

HIPAA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit disclosure of protected health information, which is any data concerning your treatment in the office. We will make every effort to comply completely with all HIPAA privacy regulations except as otherwise consented to by yourself, as set forth below. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our practice Privacy Officer.

Our Obligations:

We are required by law to:

- Maintain the privacy of protected health information except as described below.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

How we may use and disclose health information:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an Insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Screening. We may use and disclose health information pertaining to your diagnosis, care and treatment to CBCC Global, Inc. and any other CBCC affiliated entity including its agents and employees, for the purpose of cancer-related research and/or determining possible eligibility in cancer chemotherapy trials now in existence or which may arise in the future. Such screening is typically performed over time and on a random basic as new trials, protocols or experimental treatments come into existence. You will not be enrolled in any such program without your express consent and upon further discussion with your physician. Screening promotes better care for patients since new treatments may be found which did not exist when a patient was initially diagnosed and/or treated for cancer.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or conditions and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose you Protected health information to provide legally required notices or unauthorized access to or disclosure of you health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discover request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form and Consent to CBCC HIPAA Policies

Effective April 14, 2003; the law requires that Comprehensive Blood & Cancer Center provide to our patients a copy of its Notice of Privacy Practices for Health Information. By signing below, the patient acknowledges consent and receipt of such, or if you are the patient's personal representative, or authorized agent or involved in patient's medical care, you acknowledge consent and receipt of such.

Date: _____

Patient Name: _____ Responsible Party Name: _____

Patient or Responsible Party Signature: _____ Relationship to Patient: _____

Patient Financial Responsibility Assignments of Benefits

Patient Financial Responsibility Assignment of Benefits

Medicare and private insurance companies may not entirely cover the services requested by your physician and they may only pay a portion of the amount that CBCC bills to them. For example, patients are typically responsible for paying deductibles, co-insurance, and co-payments. By signing the Form you acknowledge that you are responsible for the amounts not paid by Medicare and/or your insurance company. By signing you also agree to meet with the CBCC Financial Counselor to arrange a payment plan for any outstanding balances. The counselor will work with you to make these payments as easy as possible on you and your family.

CBCC will make every effort to obtain authorization for services ordered by your physician from Medicare and/or your private insurance company. By signing this form you authorize CBCC to appeal any denials for prior authorization of services on your behalf.

We will also bill Medicare and/or your insurer for the services that we provide. By signing this form you authorize that payment of insurance benefits to CBCC for the services provided to you.

By signing the form you also authorize the release of medical information to your insurance company and to any other physicians participating in your medical care.

PET Scans: For patients receiving PET scans there is an additional obligation. Since the materials used in the PET scan must be specifically ordered for each patient, ***PET scans may only be canceled up to 24 hours before the exam is scheduled. After this time period, patients canceling a PET scan will be charged the cost of the unused dose.***

Insurance Eligibility Certification

I understand that it is my responsibility to provide CBCC with accurate information regarding my Medical Insurance Coverage. Should there be any change in my coverage, I agree that I am responsible for notifying CBCC of the changes and understand that should I fail to do so, I will be financially responsible for any resulting unpaid claims.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Consent to Digitally Sign for Copay Assistance Program Enrollment

I authorize CBCC to digitally sign any required enrollment forms or documentation on my behalf for the purpose of enrolling me in a copay assistance program related to my prescribed treatment. This consent is given voluntarily and solely to help facilitate timely access to financial assistance for my care. By providing this authorization, I confirm that I have been informed about the program, consent to enrollment, and authorize CBCC to act on my behalf for this specific purpose.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

CBCC Payment Policies

CBCC Collection Policy

Cash Pay:

- Payment in full is due at the time services are rendered.
- The patient is requested to keep an authorized credit card on file. In the event there is an unpaid balance at the time of monthly billing, this balance can be transferred to the credit card. A courtesy call will be made to the patient to arrange this transaction.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

Medicare with no Secondary Insurance:

- CBCC accepts Medicare assignment.
- The patient is responsible for payment of any deductible amount, 20% co-insurance and any non-covered services for which an Advanced Beneficiary Notice has been signed.
- Payment is due in full upon receipt of the monthly statement.
- The patient is requested to keep an authorized credit card on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

Medicare with Secondary Insurance:

- CBCC accepts Medicare assignment.
- Secondary insurance will be verified for coverage. If appropriate coverage exists, CBCC will bill the supplemental plan.
- All co-pays are due at the time of service.
- The patient is responsible for any balance unpaid by the supplemental plan and any non-covered services for which an Advanced Beneficiary Notice has been signed. This payment is due in full upon receipt of the monthly statement.

Commercial Insurance:

- Insurance plans will be verified for coverage. If appropriate coverage exists, CBCC will bill the plan(s).
- All co-pays are due at the time of service.
- The patient is responsible for any balance due after payment by the insurance plan(s).
- Payment is due in full upon receipt of the monthly statement.
- The patient is requested to keep an authorized credit on file. In the event that a balance is delinquent for greater than 30 days, following a courtesy call, the balance can be transferred to the credit card.
- Patients with financial hardship will be referred to the CBCC Financial Counselor to establish the level of need and provide available assistance.

Medical Share of Cost:

- Until the share of cost is met, the cash pay policy will be followed.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Financial Liaison Letter

Dear Patient,

Yazmin Irizarry and Virginia Gonzales are the financial counselors at CBCC & Dignity Health. Their goal is to make sure you have a solid understanding of your medical coverage, as well as your financial responsibility.

It only takes a moment to find out if you qualify for financial assistance. There are several drug manufacture co-pay programs for the commercially insured; and foundation programs for those with government insurance.

These programs may assist with your radiation, injections, infusion and chemotherapy needs. They can also provide additional resources and assistance.

If you need help determining which care is covered by insurance or what your financial obligations are, please do not hesitate to call or meet with them. The financial services office can be reached at **(661) 616-6443** or **(661) 862-7169**.

Kindest regards,

Yazmin Irizarry
Financial Counselor
(661) 616-6443
(661) 616-6443 Fax
yirizarry@cbccusa.com

Virginia Gonzales
Financial Counselor
(661) 862-7169
(661) 862-7169 Fax
vgonzales@cbccusa.com

Patient Health & Medical History Questionnaire

Date: _____

First Name: _____ Age: _____

Middle Name: _____ Ethnicity/Race: _____

Last Name: _____ Marital Status: _____

Sex: ☐ Male ☐ Female

Please answer carefully the enclosed questionnaire about your present and past medical problems and the history of your current illness. It is important that you complete each of the questions as accurately as possible so the doctor can best understand the nature of your present medical problems.

This information will become part of your permanent record and will remain confidential. The contents of this questionnaire will only be released with your written authorization.

List Your Physician(s)

Use additional pages if needed. Check box if provider is to receive a copy of today's consultation.

☐ Personal Physician: _____ Phone: _____

☐ Surgeon: _____ Phone: _____

☐ Cardiologist: _____ Phone: _____

☐ Pulmonologist: _____ Phone: _____

☐ Urologist: _____ Phone: _____

☐ Gastroenterologist: _____ Phone: _____

☐ Other: _____ Phone: _____

Your Pharmacy

Name: _____ Phone: _____

History of Present Illness

Physician Comments

What is the reason for your visit? _____

_____

_____

_____

What are your current symptoms and how long have you had them? _____

_____

_____

_____

Have you received treatment for this diagnosis?

☐ No ☐ Yes. Please give date and location of the treatment/surgery:

Surgery: _____

Radiation: _____

Drug or other therapy (chemotherapy): _____

Do you have other medical problems that are now being treated?

☐ No ☐ Yes. Please list them here:

_____

_____

_____

Past Medical History

Check the illnesses that you have had or currently have. Provide the year for those that required hospitalization:

☐ Heart Disease _____	☐ Scarlet Fever _____	☐ Kidney Disease _____
☐ Cancer _____	☐ Hepatitis _____	☐ Bronchitis *(Recurring)* _____
☐ Diabetes _____	☐ Stomach Ulcer _____	☐ Venereal Disease _____
☐ Emphysema _____	☐ Liver Disease _____	☐ Nervous Breakdown _____
☐ Hives _____	☐ Jaundice _____	☐ Bleeding Disorder _____
☐ Asthma _____	☐ Measles _____	☐ Rheumatic Fever _____
☐ Tuberculosis _____	☐ Mumps _____	☐ High Blood Pressure _____
☐ Valley Fever _____	☐ Chicken Pox _____	☐ Shingles _____
☐ Blood Clots _____	☐ Anemia _____	☐ Herpes Zoster _____
☐ Seizures _____	☐ Pneumonia *(Recurring)* _____	☐ Thyroid Disease _____

Other serious illness: _____

Have you had any of the surgeries listed below? Check and give the year:

☐ Appendix _____	☐ Stomach _____	☐ Bladder _____
☐ Breast _____	☐ Artery _____	☐ Heart Problems _____
☐ Eyes _____	☐ Colon _____	☐ Heart Surgery _____

Past Medical History *(cont.)*

Physician Comments

Have you had any of the surgeries listed below? Check and give the year:

☐ Hip _____	☐ Gallbladder _____	☐ Hernia Repair _____
☐ Lung _____	☐ Knee _____	☐ Prostate Gland _____
☐ Ovary _____	☐ Mastoids _____	☐ Thyroid Gland _____
☐ Kidney _____	☐ Nose _____	☐ Hemorrhoids _____
☐ Veins _____	☐ Tubes Tied _____	☐ Tonsil & Adenoids _____
☐ Bone Marrow _____	☐ Uterus _____	☐ Dilatation & Curettage _____

Other surgeries: _____

_____

Have you ever had problems with anesthesia?

☐ No ☐ Yes: Please state the problem: _____

Have you ever had radiation treatment?

☐ No ☐ Yes: What part(s) of the body: _____

Have you ever had serious accidents or injuries?

☐ No ☐ Yes: Please describe: _____

Have you ever had blood transfusions?

☐ No ☐ Yes: List how many: _____

Medications

List the names of any medications that you take regularly:

Name:	Dose:	Frequency:	Date Started:

Would you like to have some of your prescriptions filled at our office? ☐ No ☐ Yes

Vaccination Information

Flu Shot

Date Taken: _____ Location: ☐ Left Arm ☐ Right Arm

Covid-19

1st Dose: _____ Location: ☐ Left Arm ☐ Right Arm

2nd Dose: _____ Location: ☐ Left Arm ☐ Right Arm

Booster: _____ Location: ☐ Left Arm ☐ Right Arm

Manufacturer: ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson

Allergies

Physician Comments

Medication/Food:	Reaction:	Date First Occurred:

Personal Habits

List the jobs you have held: _____

_____

_____

Have you ever been exposed to any of the following?

Radiation ☐ No ☐ Yes
Petroleum Products ☐ No ☐ Yes
Industrial Toxins ☐ No ☐ Yes
Insecticides ☐ No ☐ Yes
Benzene ☐ No ☐ Yes

Smoking:

☐ Yes, current every day smoker. Number of years: _____ Packs per day: _____
☐ Yes, occasional smoker. Number of years: _____ Packs per week: _____
☐ Previously smoked, but quit. Years quit: _____
☐ Never smoked

Do you drink alcohol? ☐ No ☐ Yes: List amount & type: _____
Have you been on a diet in the past? ☐ No ☐ Yes: List type and reason: _____
Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)? ☐ No ☐ Yes

Religious Beliefs *(optional)*

Do you have a religious background? ☐ No ☐ Yes: Explain: _____
Will your religious beliefs have an important role in your treatment? ☐ No ☐ Yes
Would you like a doctor, nurse or other staff member to pray with you? ☐ No ☐ Yes

Cancer Screening

Have you had any of the following tests? If yes, when and where?

Mammogram ☐ No ☐ Yes When: _____ Where: _____
Pap Smear ☐ No ☐ Yes When: _____ Where: _____
Prostate Exam ☐ No ☐ Yes When: _____ Where: _____
PSA ☐ No ☐ Yes When: _____ Where: _____
Colon Exam ☐ No ☐ Yes When: _____ Where: _____
Skin Exam ☐ No ☐ Yes When: _____ Where: _____
Chest X-Ray ☐ No ☐ Yes When: _____ Where: _____
Other: _____ When: _____ Where: _____

General Health Family History

Physician Comments

List the members of your immediate family, their ages, current health status and if deceased, their age of death.

	Age	Health Status			Cause of Death & Age
		Good	Fair	Poor	
Mother		☐	☐	☐	
Father		☐	☐	☐	
Sister(s)		☐	☐	☐	
Brother(s)		☐	☐	☐	
Daughter(s)		☐	☐	☐	
Son(s)		☐	☐	☐	

List others here: _____

_____

_____

_____

_____

Are you of Ashkenazi Jewish heritage? ☐ No ☐ Yes

Has any family member had a blood disease?

☐ No ☐ Yes: List relationship and type of blood disease: _____

_____

_____

Do you have any birth defects in your family history?

☐ No ☐ Yes: Please explain: _____

_____

_____

Are you a twin? ☐ No ☐ Yes

Were you born with a birth defect?

☐ No ☐ Yes: Please explain: _____

_____

_____

Cancer Family History

Physician Comments

Write in the ***age*** of each cancer diagnosis in the box below for yourself and each family member who has been diagnosed with cancer as indicated.

	Breast Cancer	Male Breast Cancer	Colon Cancer	Prostate Cancer	Pancreatic Cancer	Endometrial Cancer	Ovarian Cancer	Other *Fill in cancer type & age diagnosed.*
Yourself	☐	☐	☐	☐	☐	☐	☐	
Mother	☐		☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐		
Sister(s)	☐		☐	☐	☐	☐	☐	
Brother(s)		☐	☐	☐	☐	☐		
Daughter(s)	☐		☐	☐	☐	☐	☐	
Son(s)		☐	☐	☐	☐	☐		
MOTHER'S SIDE								
Grandmother	☐		☐	☐	☐	☐	☐	
Grandfather		☐	☐	☐	☐	☐		
Aunt(s)	☐		☐	☐	☐	☐	☐	
Uncle(s)		☐	☐	☐	☐	☐		
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	
FATHER'S SIDE								
Grandmother	☐		☐	☐	☐	☐	☐	
Grandfather		☐	☐	☐	☐	☐		
Aunt(s)	☐		☐	☐	☐	☐	☐	
Uncle(s)		☐	☐	☐	☐	☐		
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	

☐ Family history unknown.

Review of Systems

Physician Comments

Do you have, or have you had ***in the last 6 months***, any of the following?

General weakness	☐ No	☐ Yes
Skin rashes	☐ No	☐ Yes
Change in taste	☐ No	☐ Yes
Sores not healing	☐ No	☐ Yes
Fever of unknown cause	☐ No	☐ Yes
Weight loss without cause	☐ No	☐ Yes
Enlarging moles	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes
Chills	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Do you have frequent/recurring headaches?	☐ No	☐ Yes
Do you have frequent dizzy spells?	☐ No	☐ Yes
Have you ever fainted?	☐ No	☐ Yes
Have you had a recent change in eyesight?	☐ No	☐ Yes
Have you had a recent change in hearing?	☐ No	☐ Yes
Do you have ringing or roaring in your ears?	☐ No	☐ Yes
Do you wear dentures?	☐ No	☐ Yes
Do they fit properly?	☐ No	☐ Yes
Do you have frequent sore throats?	☐ No	☐ Yes
Do you have trouble swallowing?	☐ No	☐ Yes
Do you have hoarseness without colds?	☐ No	☐ Yes
Have you lumps or swelling in the neck?	☐ No	☐ Yes
Do you cough up a lot of phlegm?	☐ No	☐ Yes
Have you coughed up blood?	☐ No	☐ Yes
Do you have coughing spells?	☐ No	☐ Yes
Do you have shortness of breath without exercise?	☐ No	☐ Yes
Do you have shortness of breath with exercise?	☐ No	☐ Yes
Have you had pains in your chest?	☐ No	☐ Yes
Have you been treated for heart problems?	☐ No	☐ Yes
Have you had high blood pressure?	☐ No	☐ Yes
Have you had thumping or racing heart?	☐ No	☐ Yes
Do your ankles swell?	☐ No	☐ Yes
Do you have frequent indigestion?	☐ No	☐ Yes
Do you have pain in your stomach?	☐ No	☐ Yes
Have you had frequent nausea or vomiting?	☐ No	☐ Yes
Have you ever vomited blood?	☐ No	☐ Yes
Have you had black bowel movements?	☐ No	☐ Yes

Review of Systems *(cont.)*

Physician Comments

Do you ***currently*** have any of the following?

Have your bowel movements changed in the last 6 months?	☐ No ☐ Yes
Have you had blood in your bowel movements?	☐ No ☐ Yes
Do you notice burning on urination?	☐ No ☐ Yes
Do you get up every night to urinate?	☐ No ☐ Yes
Have you passed blood in urine?	☐ No ☐ Yes
Have you passed a kidney stone?	☐ No ☐ Yes
Have you had root beer colored urine?	☐ No ☐ Yes
Any change in your desire for sexual activity?	☐ No ☐ Yes
Any change in your ability to engage in sexual activity?	☐ No ☐ Yes
Do you have joint trouble?	☐ No ☐ Yes
Do you have constant back pain?	☐ No ☐ Yes
Do you have constant bone pain?	☐ No ☐ Yes
Do your bruise easily?	☐ No ☐ Yes
Do you bleed easily?	☐ No ☐ Yes
Do your gums bleed frequently?	☐ No ☐ Yes
Do you have prolonged bleeding with cuts?	☐ No ☐ Yes
Do you have frequent nosebleeds?	☐ No ☐ Yes
Do you have feelings of sadness, depression or anxiety?	☐ No ☐ Yes

FOR MEN ONLY

Do you have trouble urinating?	☐ No ☐ Yes
Have you been told you have prostate problems?	☐ No ☐ Yes
Have you been circumcised?	☐ No ☐ Yes

Breast Health History *(Women Only)*

Do you conduct breast self exams?	☐ No ☐ Yes
Do you feel palpable lumps?	☐ No ☐ Right ☐ Left ☐ Both
Do you have nipple discharge?	☐ No ☐ Right ☐ Left ☐ Both
Do you have nipple inversion?	☐ No ☐ Right ☐ Left ☐ Both
Has the size or shape of the nipples changed?	☐ No ☐ Right ☐ Left ☐ Both
Have you had any breast trauma?	☐ No ☐ Right ☐ Left ☐ Both
Have you had any breast cyst aspirated?	☐ No ☐ Right ☐ Left ☐ Both
Do you feel breast pain?	☐ No ☐ Right ☐ Left ☐ Both
If yes, is the pain related to periods?	☐ No ☐ Yes
Have you had any prior breast surgery?	☐ No ☐ Yes

Type of surgery: ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy

If yes, check which side and list diagnosis year and where the surgery was preformed:

☐ Left Diagnosis, list year: _____, where: _____

☐ Right Diagnosis, list year: _____, where: _____

Gynecologic History *(Women Only)*

Physician Comments

Have you ever taken hormones? ☐ No ☐ Yes

If yes, give type: _____ Duration: _____ Stopped: _____

Have you ever taken birth control pills? ☐ No ☐ Yes

If yes, when were they started? _____ When were they stopped? _____

How old were you when you began menstruating? _____

Do you bleed between your periods? ☐ No ☐ Yes

Do you still have periods?

☐ Yes, indicate date of first day of last period: _____

☐ No, check reason: ☐ Natural, at what age? _____ ☐ Surgery, at what age? _____

Are you currently pregnant? ☐ No ☐ Yes

Are you interested in having more children? ☐ No ☐ Yes

Age when you first became pregnant with your first full-term pregnancy? _____

Have you had any complications of pregnancy? ☐ No ☐ Yes, describe: _____

_____

_____

_____

Did you breast feed? ☐ No ☐ Yes, for _____ months.

Please indicate the following:

Number of pregnancies: _____ Number of premature births: _____

Number of cesareans: _____ Number of abortions: _____

Number of miscarriages: _____ Number of children born alive: _____

Number of stillborn: _____