NORTHSHORE
ONCOLOGY ASSOCIATES LLC

Today's Date: _____

NEW PATIENT INFORMATION

Last Name: _____ SSN: _____
First Name: _____ Middle Initial: _____ DOB: _____ Sex: _____
Email: _____ Marital Status: _____
Phone (H): _____ Phone (W): _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____
Employer: _____
Emergency Contact: _____ Phone: _____
Relationship: _____
Referring Physician: _____ Primary Care Physician: _____

EVACUATION CONTACT

_____
Name

_____
Phone Number

_____
Signature of Patient (authorizing evacuation contact disclosure in the event of an emergency)

Please Check One:

☐ I have executed an advanced directive
☐ I have not executed an advanced directive

Religion: (please check)

☐ Atheist
☐ Baptist
☐ Catholic
☐ Christian Scientist
☐ Episcopalian
☐ Hindu
☐ Jehovah's Witness
☐ Jewish
☐ LDS (Mormon)
☐ Lutheran
☐ Methodist
☐ Moslem
☐ Non-Denominational
☐ Other
☐ Pentacostal
☐ Presbyterian
☐ Protestant

Ethnic Origin: (please check)

☐ African American
☐ Caucasian
☐ Native American
☐ Unknown
☐ Asian
☐ Hispanic
☐ Mixed

Primary Language: _____

RESPONSIBLE PARTY INFORMATION - if different from above

Last Name: _____ SSN: _____
First Name: _____ Middle Initial: _____ DOB: _____ Sex: _____
Marital Status: _____ Phone (H): _____
Address: _____ Phone (W): _____
_____ Cell Phone: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Address: _____

INSURANCE INFORMATION

****We will copy your insurance card(s); please indicate primary and secondary****

Primary Insurance: _____ Secondary Insurance: _____

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DESIGNATION OF PERSONAL REPRESENTATIVE

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization, you are informing us of your designation of the named person as your personal representative. The designation may be revoked at any time by the signing and dating the revocation of your copy of the form and returning it to the HIM Department at Mary Bird Perkins Cancer Center.

I, _____ hereby designate the following individuals to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

1. _____ RELATION: _____

2. _____ RELATION: _____

It is my understanding that this person will be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: _____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Mary Bird Perkins Cancer Center, HIM Department, 5745 Essen Crossing Suite 100, Baton Rouge, Louisiana 70810. I further understand that such revocation does not apply to the extent that person who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

_____ _____

Signature Date

REVOCATION

I hereby revoke this designation of a personal representative.

_____ _____

Signature Date

HEALTH HISTORY

Name: _____ Date: _____
Reason for visit: _____
Age: _____ Sex: Male Female (circle one) Marial Status: Single Married Divorced Widowed (circle one)
No. of children: _____ Type of Work: _____
Primary Physician: _____

TELL US ABOUT YOUR HEALTH:
Do you have or have you ever had:
☐High Blood Pressure ☐Diabetes (high blood sugar) ☐Lung Disease ☐Liver Disease
☐Angina ☐Kidney Disease ☐Heart Disease ☐Heart Failure
☐Sexually Transmitted Disease ☐Other: _____

Have you ever had any surgeries?
☐Tonsils removed ☐Adenoids removed ☐Appendix removed ☐Gallbladder removed
☐Other: _____

Have you ever had blood transfusions? ☐Yes ☐No
What year? _____

Do you smoke? ☐Never ☐Former Smoker ☐ Current Smoker
If YES: How long? _____
How much? _____
If NO: Did you ever smoke? ☐Yes ☐No
If yes: How long? _____
How much? _____
When did you stop? _____

Do you drink alcoholic beverages? ☐Yes ☐No
If YES: How long? _____
How much? _____
If NO: Did you ever drink? ☐Yes ☐No
If yes: How long? _____
How much? _____
When did you stop? _____

Have you ever used drugs (like marijuana, cocaine, etc.)? ☐Yes ☐No

FAMILY HISTORY

Father: ☐Alive Age: _____ State of Health: _____
Health problems: ☐Cancer ☐High Blood Pressure ☐High Blood Sugar ☐Heart Disease
☐Deceased Age at Death: _____

Mother: ☐Alive Age: _____ State of Health: _____
Health problems: ☐Cancer ☐High Blood Pressure ☐High Blood Sugar ☐Heart Disease
☐Deceased Age at Death: _____

Siblings/Children:	Alive		Age	State of Health	Deceased		Age (at death)
Brother or Sister	☐Yes	☐No	_____	_____	☐Yes	☐No	_____
Brother or Sister	☐Yes	☐No	_____	_____	☐Yes	☐No	_____
Brother or Sister	☐Yes	☐No	_____	_____	☐Yes	☐No	_____
Son or Daughter	☐Yes	☐No	_____	_____	☐Yes	☐No	_____
Son or Daughter	☐Yes	☐No	_____	_____	☐Yes	☐No	_____

Any blood relatives (grandparents, uncles, aunts, first degree cousins, nieces, and/or nephews) with any of the following:
☐Cancer ☐Diabetes (high blood sugar) ☐High Blood Pressure ☐Heart Disease ☐Stroke

REVIEW OF SYSTEMS

General
- ☐ Chills
- ☐ Fever
- ☐ Loss of weight
- ☐ Sweats
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headaches (migraines)
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Bleeding Disorders

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Eye
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision-flashes or halos
- ☐ Glaucoma
- ☐ Eye glasses or contacts
- ☐ Cataracts

Nose
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Sinus problems

Mouth/Throat
- ☐ Bleeding gums
- ☐ Hoarseness

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Pulmonary
- ☐ Asthma
- ☐ Persistent cough
- ☐ Shortness of breath
  - ☐ At rest
  - ☐ On exertion
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ Pain in chest

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Genito-urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Frequent infections
- ☐ Difficulty urinating

Muscle/Joint/Bone
Pain, weakness, numbness

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulder
- ☐ Arthritis

Neurological
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Hospitilization
- ☐ Anxiety
- ☐ Alcohol or drug addiction

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Women only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

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ALLERGY AND MEDICATIONS SHEET

The medicines that you take are part of your health information. Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. If you need more space to list your medicines, ask for another form. Please do not write on the back of this form.

Patient Name: _____ Date: _____

ALLERGIES

☐ Check if none

Name of Substance (medication or food)	Type of Reaction

Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing, etc.? ☐Yes ☐No

Medications (Prescription and over-the-counter)	**Strength** (such as mg, ml, units, etc.)	**Directions** (such as 1 tablet in the a.m.) Check box if taken only as needed	**Prescribed by**
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

Pharmacy Name: _____ Location: _____
Phone#: _____ Primary Care Physician: _____
Other Physicians: _____
Would you like a copy of your clinical summary? ☐Yes ☐No
(Includes a list of medications, allergies, diagnosis, laboratory results)