Halifax Health – Center for Oncology

Daytona Beach	Ormond Beach	New Smyrna	Port Orange
303 N Clyde Morris Blvd	1688 W. Granada Blvd	401 Palmetto St	1185 Dunlawton Ave #105
Daytona Beach, FL	Ormond Beach, FL	New Smyrna Beach, FL	Port Orange, FL
(386) 425-4210	**(386) 425-4400**	**(386) 424-5038**	**(386) 425-4750**
(386) 425-4212		**(386) 424-6327**	
(386) 425-4034			

MEDICAL HISTORY AND MEDICATION SUMMARY

Weight	
Height	
Temp	
B/P	
Pulse	
Respirations	
Pain	

Date: _____

Dear Patient: ***Please take the time to fill out these forms completely and bring them with you on your first visit***.

Your Name: _____DOB:_____ Age:_____ Sex:☐ Male ☐ Female

Your Preferred Name:_____ Home Phone: _____Cell Phone: _____

Occupation (if retired, former occupation)_____ Work phone:_____

Why are you seeing the doctor today? _____

Referring or Primary Care Physician:_____ Other Physicians_____

Preferred Medical Communication Language:
English ☐ Spanish ☐ Other ☐ _____

Alternative Local Contact

Name: _____ Relationship: _____ Phone: _____Cell: _____

Emergency Contact
Name: _____ Relationship:_____ Phone: _____ Cell: _____

Pharmacy
Name: _____ Location: _____ Phone: _____

Cancer Screening (Please give approximate date of the following cancer screenings)

Last PAP Smear (females) _____ Last Mammogram (females) _____

Last Colonoscopy _____ Last PSA (males) _____

Do you have any metal or implanted devices in your body? ☐ No ☐ Yes _____

Have you ever had Radiation treatment? ☐ No ☐ Yes
If Yes, when and where?_____

Have you ever had Chemotherapy? ☐ No ☐ Yes
If Yes, when and where?_____

Have you had a flu vaccine? ☐ No ☐Yes - When_____

Have you had a pneumonia vaccine? ☐ No ☐Yes - When_____

Do you have signed Advanced Directives?

- **Living Will?** ☐ Yes ☐ No
- **Designation of Health Care Surrogate?** ☐ Yes ☐ No
- **Durable Power of Attorney for Health Care?** ☐Yes ☐ No

If "Yes" to the above, we would appreciate a copy for our records. If "No," would you like information? ☐Yes ☐ No

Print Your Name:_____

Your Signature: _____**Date**:_____

NAME: _____ **Date of Birth:** _____ **Date:** _____

*****MEDICAL PROBLEMS AND SURGERIES *** (Please check all that apply and give approximate YEAR):**

MEDICAL HISTORY			
PROBLEM	**DATE/YEAR**	**PROBLEM**	**DATE/YEAR**
☐Alzheimer's Disease		☐Hemorrhoids	
☐Anemia		☐Hepatitis	
☐Angina		☐HIV/AIDS	
☐Anxiety		☐Hypercholesterolemia	
☐Arthritis		☐Hypertension	
☐Asthma		☐Inflammatory Bowel Disease	
☐Bleeding Problems		☐Irregular Heartbeat	
☐Blood Clots		☐Kidney Stones	
☐Blood Disorders		☐Liver Problems	
☐Cancer		☐Lupus	
☐Cardiovascular Disease		☐Melanoma	
☐Cataracts		☐Migraine Headaches	
☐Cirrhosis		☐Multiple Sclerosis	
☐Colitis		☐No Known Medical Problems	
☐Collagen Vascular Disease		☐Osteoarthritis	
☐COPD		☐Osteoporosis	
☐Coronary Artery Disease		☐**Pacemaker(we will need your card)**	
☐Coronary Stent		☐Parkinson's Disease	
☐Crohn's Disease		☐Peptic Ulcer Disease	
☐**Defibrillator(we will need your card)**		☐Peripheral Neuropathy	
☐Diabetes: Type 1		☐Peripheral Vascular Disease	
☐Diabetes: Type 2		☐Pneumonia	
☐Difficulty With Erections		☐Previous Cancer Surgery	
☐Diverticulitis		☐Prostate	
☐Diverticulosis		☐Rheumatoid Arthritis	
☐Emphysema		☐Scleroderma	
☐Epilepsy		☐Seizure	
☐Fall Risk Level 1- sensorium & coordination		☐Stroke	
☐GERD (Gastroesophageal Reflux)		☐Thyroid Problems	
☐Glaucoma		☐TIA	
☐Gout		☐Upper Endoscopy	
☐Heart Attack		☐Uterine Fibroids	
☐Heart Disease		☐Other _____	
☐Heart Valve Disease			

SURGICAL/PROCEDURES	DATE/YEAR	SURGICAL/PROCEDURES	DATE/YEAR
☐Amputation_____		☐Knee Surgery Left	
☐Appendectomy		☐Knee Surgery Right	
☐Biopsy _____		☐Lumpectomy	
☐Bone Marrow Transplant		☐Mastectomy	
☐Breast Biopsy		☐Melanoma Removal	
☐Cataracts		☐Multiple Biopsies	
☐Cholecystectomy		☐No Known Surgical/Procedure	
☐Colon		☐Ovarian Tumor Removal	
☐Colon Resection		☐Plastic Surgery	
☐Colonoscopy		☐Prostate Gland Removal	
☐Colposcopy		☐Sigmoidoscopy	
☐Cystectomy		☐Thyroidectomy	
☐Gall Bladder		☐Tonsillectomy	
☐Heart By-Pass		☐Tubal Ligation	
☐Hernia Repair		☐Vasectomy	
☐Hip Surgery Left		☐Wide Re-excision	
☐Hip Surgery Right		☐Other _____	
☐Hysterectomy (complete)		☐Other _____	
☐Hysterectomy (partial)			

NAME: _____ **Date of Birth:** _____ **Date:** _____

OB/GYN HISTORY

PREGNANCIES		MENSTRUATION (MENSES)		MENOPAUSE STATUS	MENOPAUSE DETAILS	
# of pregnancies (Gravida)		Menses Start Age		☐ Yes	Age at menopause	
# of births (Para)		Last Menstrual Period		☐ No		
Age at First Birth		Menstrual Cycle Length			Menopause Reason	☐ Surgical
# of Interrupted Pregnancies				☐ Unknown		☐ Natural
				☐ No Answer		
				LAST TESTS		
HORMONE USE				☐ Pap		
☐ Contraceptive Use		# years used		☐ Mammogram		
☐ Post - Menopause Use		# years used				
☐ Other Hormone Use		# years used & why:		_____		

FAMILY HISTORY OF CANCER

MEMBER	AGE	ALIVE	AGE OF DEATH	MEDICAL PROBLEMS
Father		☐Yes ☐No		
Mother		☐Yes ☐No		
Maternal Grandmother		☐Yes ☐No		
Maternal Grandfather		☐Yes ☐No		
Paternal Grandmother		☐Yes ☐No		
Paternal Grandfather		☐Yes ☐No		
Brother		☐Yes ☐No		
Brother		☐Yes ☐No		
Sister		☐Yes ☐No		
Sister		☐Yes ☐No		
Son		☐Yes ☐No		
Daughter		☐Yes ☐No		

SOCIAL HISTORY

SMOKING				SUBSTANCES/PRODUCTS
☐Yes - Active		# Years		☐No known products
☐Yes - Occasional		# Packs/Day		☐Cigarettes
☐Yes - But quit		Pack Years		☐Chewing tobacco
☐Never		Years Quit		☐Cigars
☐Unknown				☐Snuff
				☐Pipe
ALCOHOL CONSUMPTION				☐Liquor
☐Yes - Active		# Days/Week		☐Beer
☐Yes - Occasional		# Drinks/Day		☐Wine
☐Yes - But quit		# Drinks/Day		☐ Illicit or recreational drug use
☐Never				☐Marijuana
☐Unknown		Years Quit		☐Narcotics

NAME: _____ **Date of Birth:** _____ **Date:** _____

*****SYSTEM REVIEW: (Please check all that apply):*****

Constitutional:	**Allergic:**	**Head:**	**Eyes:**	**ENT:**
☐ Loss or decrease of Appetite ☐ Fatigue ☐ Fever ☐ Lethargy/malaise ☐ Night Sweats ☐ Chills ☐ Recent unplanned weight loss How much? _____	☐ Allergies ☐ Yes ☐ No (see medication list on next page)	☐ Alopecia (Hair Loss)	☐ Double or blurred vision ☐ Weeping eye (lacrimation) ☐ Night blindness ☐ Sensitive to light (photophobia) ☐ Wear contacts or eyeglasses ☐ Eye disease or injury ☐ Blind? Which eye(s) _____	☐ Difficulty swallowing (dysphagia) ☐ Ear pain or drainage ☐ Nosebleeds(epistaxis) ☐ Difficulty hearing ☐ Hearing Aids Lt Rt ☐ Sore or dry throat ☐ Oral bleeding ☐ Ear infection (otitis) ☐ Sinusitis ☐ Mucus,phlegm(sputum) ☐ Mouth sores ☐ Taste altered ☐ Ringing in ears (tinnitus)

Neck:	**Integumentary:**	**Breasts:**	**Cardiovascular:**	**Respiratory:**
☐ Masses ☐ Muscle weakness ☐ Pain ☐ Range of motion ☐ Swelling	☐ Blisters ☐ Bruising ☐ Dry skin ☐ Facial burning ☐ Nails ☐ Photosensitivity ☐ Itching (pruritus) ☐ Rash ☐ Hives (urticaria)	☐ Any lumps or swollen glands ☐ Nipple discharge ☐ Nipple inversion ☐ Pain	☐ Arrhythmia ☐ Chest pain or angina pectoris ☐ Shortness of breath while walking (dyspnea) ☐ Swollen feet, ankles or legs (edema) ☐ Shortness of breath while lying flat (orthopnea) ☐ Palpitations	☐ Chronic daily or frequent cough ☐ Coughing up Sputum Color_____ ☐ Shortness of breath while walking (dyspnea) ☐ Coughed up blood (hemoptysis) ☐ Hiccoughs ☐ Pleuritic chest pain ☐ Wheezing

Gastrointestinal:	**Genitourinary:**	**Musculoskeletal:**	**Neurologic:**	**Psychiatric:**
☐ Abdominal pain ☐ Bowel frequency _____ ☐ Constipation ☐ Frequent diarrhea ☐ Heart burn/ GERD ☐ Coughing up blood (hematemesis) ☐ Rectal bleeding or blood in stool (hematochezia) ☐ Hemorrhoids ☐ Nausea or vomiting ☐ Cramping ☐ Fullness (satiety) ☐ Vomiting	☐ Painful urination (dysuria) ☐ Frequency/Urgency ☐ Genital masses ☐ Blood in urine (hematuria) ☐ Incontinence ☐ Nocturia ☐ Renal stone disease ☐ Impotence ☐ Difficulty maintaining an erection ☐ Urine color change ☐ Vaginal discharge/bleeding ☐ Vaginal spotting	☐ Arthritis ☐ Bone pain ☐ Joint pain, stiffness, or swelling ☐ Muscle weakness ☐ Range of motion	☐ Disorientation ☐ Dizziness ☐ Abnormal gait (unsteady on feet) ☐ Headaches ☐ Insomnia ☐ Memory loss ☐ Neuropathy-motor ☐ Paralysis or weakness of one body side ☐ Seizures ☐ Numbness or tingling (sensory problems) ☐ Stroke	☐ Delusions ☐ Hallucinations ☐ Depression ☐ Euphoria ☐ Mood swings ☐ Schizophrenia

Endocrine:	**Hematology:**	**Dermatology:**		
☐ Diabetes ☐ Hot flashes ☐ Menstrual irregularities ☐ Thyroid disease	☐ Easy bruising ☐ Lymph nodes ☐ Anemia	☐ Rash or itching ☐ Unusual mole ☐ Mole changing size or color ☐ Skin Cancer ☐ Keloid		

NAME: ___________________________________ Date of Birth: _____________________ Date: _________________

HALIFAX HEALTH
CENTER FOR ONCOLOGY
UNIVERSAL MEDICATION FORM

PATIENT:

1. Write down all of the medicines you are taking and your allergies.
2. In the Notes column, write down the name of the doctor who told you to take the medicine(s). You may also write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).

ALLERGIES: Are you allergic to any medications? ☐ **No** ☐ **Yes**
If yes, please list medication/food/vitamin supplement and what type of bad reactions you had:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over the counter medications (example: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerine)

DATE	NAME OF MEDICATION & DOSE	DIRECTIONS	DATE STOPPED	NOTES: Reason for taking & Doctor

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(386) 425-4211	**(386) 425-4400**	**(386) 424-5038**	**(386) 425-4750**

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

SPECIAL AUTHORIZATION TO RELEASE INFORMATION

Medical Oncology Fax: (386) 254-4214
Radiation Oncology Fax: (386) 254-4383
New Smyrna Beach Fax: (386) 424-5081

Patient Name _____ Medical Record # _____

Address _____ Phone # _____

Date of Birth _____ Date Information Needed ____/____/____ Mail____ Pick Up____ Fax # _____

I hereby authorize Halifax Health to use and **disclose to**: ☐ or **obtain from**: ☐

_____ _____
NAME OF FACILITY OR PERSON PHONE

_____
STREET ADDRESS CITY STATE ZIP

The following information contained in my medical record regarding my hospitalization, care and treatment:
☐ Emergency Record ☐ Radiology Reports ☐ Pathology Reports ☐ Treatment Plan
☐ Discharge Summary ☐ History & Physical ☐ Operative Reports ☐ Medication Record
☐ Laboratory Results ☐ Consultants Reports ☐ Psychosocial Assessment
☐ Pertinent Information (includes above) ☐ Other (please specify) _____

Date(s) of Service: _____

The purpose for release of information at the request of the individual is:
☐ Insurance ☐ Legal action ☐ Continuing care ☐ Other (specify) _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designed above unless checked below. I understand this authorization extends to release of information via U.S. mail, telephone or facsimile machine (fax).

May NOT include information related to: ☐ HIV/AIDS ☐ Mental Health ☐ Substance Abuse (Alcohol/Drugs) ☐ Genetic Testing

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the **Halifax Health – Center for Oncology, Medical Records Department, at 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114**. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and federal confidentiality laws or regulations may not protect the information. If I have questions about disclosure of my health information, I can contact the Halifax Health Privacy Official at (386) 254-4040, ext. 3161.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____
IF SIGNED BY LEGAL REPRESENTATIVE, DESCRIPTION OF AUTHORITY TO ACT ON BEHALF OF THE INDIVIDUAL

FEES FOR REPRODUCTION ARE AVAILABLE UPON REQUEST

This information is being disclosed to you from records whose confidentiality is protected by Fed. Law 42CFR, part 2, which prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose

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(386) 425−4211	(386) 425−4400	(386) 424−5038	(386) 425−4750

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

AUTHORIZATION TO RELEASE MEDICAL INFORMATION CONCERNING OUTPATIENT TREATMENT TO FAMILY MEMBERS FOR CARE AND NOTIFICATION PURPOSES

We are frequently contacted by individuals, identifying themselves as family members or friends, who request information about a patient's condition. To protect your privacy, we will not discuss your medical condition with anyone without your consent. Please complete the following if you want us to share information regarding your medical condition with members of your family or friends.

I, _____, PIN #_____, hereby authorize the Center for Oncology, and/or my physician, _____, to release information regarding my medical condition and treatments to the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Information that I do not want shared with these individuals include:_____

_____

_____

I understand that this document applies only to outpatient treatment at the Halifax Health – Center for Oncology, and is valid for the extent of my treatment, unless I provide a specific date, and the document will become a permanent part of my medical record. I understand that it is my sole responsibility to complete another authorization form should I decide to add or remove individuals from this list.

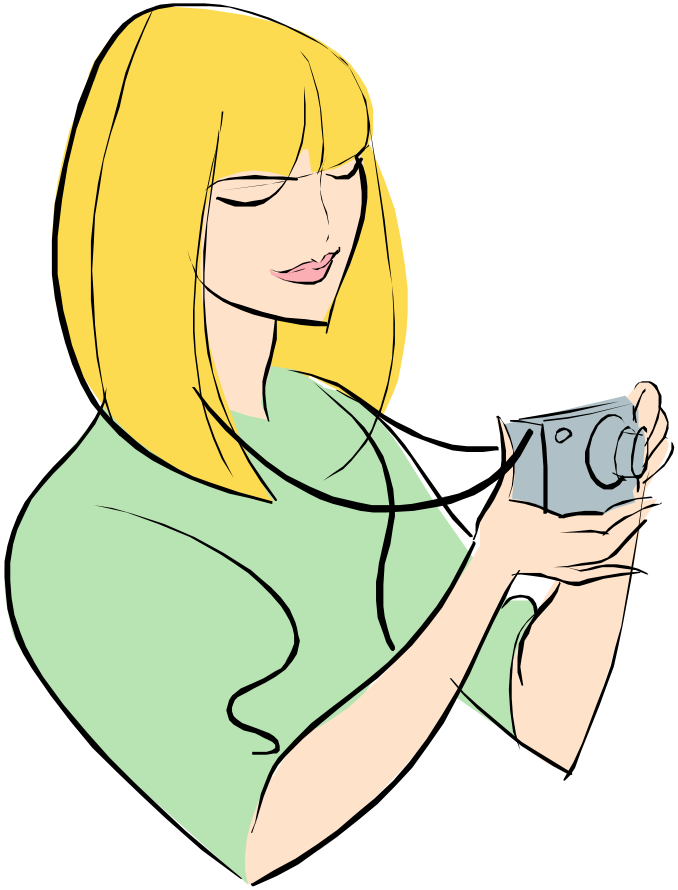
Patient or Legal Representative:_____ Date:_____

Relationship if not patient:_____

Patient unable to sign because:_____

Witness:_____ Date:_____

For your first appointment in Radiation Therapy, a picture of you will be taken to confirm your identity and will become part of your medical records with us.



For our staff to take your picture, two forms of identification, one with a photo, will be necessary. Please plan to bring identification with you.

Thank You