For Medical Staff Use Only

Halifax Health – Center for Oncology

303 N Clyde Morris Blvd
Daytona Beach, FL
(386) 425-4212 **MedOnc**
(386) 425-4211 **GynOnc**
(386) 425-4210 **RadOnc**

1688 W. Granada Blvd.
Ormond Beach, FL
(386) 425-4400

401 Palmetto St
New Smyrna Beach, FL
(386) 424-5038
(386) 424-6327

1185 Dunlawton Ave, Ste 105
Port Orange, FL
(386) 425-4750

Weight	
Height	
Temperature	
B/P	
Pulse	
Respirations	
Pain level	

Medical History and Medication Summary

Please fill out these forms completely and accurately and bring them with you to your first appointment in Oncology along with your Photo ID and insurance cards. We will take your photo for your ID badge at your first appointment.

Name:_____ **Date of Birth:**_____ **Sex:** ☐ Male ☐ Female

Your Preferred Name: _____ **Home Phone:** _____ **Cell Phone:** _____

Occupation (if retired, former occupation): _____ **Work Phone:** _____

Why are you seeing the Dr? _____ **Primary Care Dr:** _____

Physicians you have seen in the last 2 years? _____

_____

Preferred Communications Language (English, Spanish, Other): _____

Email Address where we can send medical information: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Alternate Contact Name: _____ Relationship: _____ Phone: _____

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) _____

Have you ever had Radiation treatment? _____ If yes, when and where? _____

Have you ever had Chemotherapy? _____ If yes, when and where? _____

Do you have any metal or implanted devices in your body? If yes, where? _____

Vaccines Flu? ☐ Pneumonia? ☐ Covid? ☐ If you have received the Covid vaccine, which brand?_____
Booster? ☐ ☐ (Moderna, Pfizer, Johnson and Johnson?)

Do you have signed advanced directives?

- Living Will? ☐
- Designation of Healthcare Surrogate? ☐
- Durable Power of Attorney for Healthcare? ☐

If yes, please provide a copy for our records. If no, would you like information? ☐

Print Your Name: _____

Your Signature: _____ Today's Date: _____

MEDICAL PROBLEMS AND SURGERIES
Please check all that apply and give approximate date.

Problem	Year	Problem	Year	Surgery/ Procedure	Year
☐ Alzheimer's Disease		☐ Hemorrhoids		☐ Amputation _____	
☐ Anemia		☐ Hepatitis		☐ Appendectomy	
☐ Angina		☐ HIV/AIDS		☐ Biopsy _____	
☐ Anxiety		☐ Hypercholesterolemia		☐ Cataracts	
☐ Arthritis		☐ Hypertension (High blood pressure)		☐ Cholecystectomy (Gallbladder)	
☐ Asthma		☐ Inflammatory Bowel Disease		☐ Colon	
☐ Bleeding Problems		☐ Irregular Heartbeat		☐ Colon Resection	
☐ Blood Clots		☐ Kidney Stones		☐ Colonoscopy	
☐ Blood Disorders		☐ Liver Problems		☐ Colposcopy	
☐ Cancer		☐ Lupus		☐ Cystectomy	
☐ Cardiovascular Disease		☐ Melanoma		☐ Heart bypass	
☐ Cataracts		☐ Migraine Headaches		☐ Hernia Repair	
☐ Cirrhosis		☐ Multiple Sclerosis		☐ Hip Surgery (Left)	
☐ Colitis		☐ Osteoarthritis		☐ Hip Surgery (Right)	
☐ Collagen Vascular Disease		☐ Osteoporosis		☐ Hysterectomy	
☐ COPD		☐ Pacemaker (We will need your implant card at the front desk)		☐ Knee Surgery (Left)	
☐ Coronary Artery Disease		☐ Parkinson's Disease		☐ Knee Surgery (Right)	
☐ Crohn's Disease		☐ Peptic Ulcer Disease		☐ Lumpectomy	
☐ Defibrillator (We will need your implant card at the front desk)		☐ Peripheral Neuropathy		☐ Mastectomy	
☐ Diabetes: Type 1		☐ Peripheral Vascular Disease		☐ Melanoma Removal	
☐ Diabetes: Type 2		☐ Pneumonia		☐ Multiple Biopsies	
☐ Difficulty with erections		☐ Previous Cancer Surgery		☐ Ovarian Tumor	
☐ Diverticulitis		☐ Prostate		☐ Plastic Surgery	
☐ Diverticulosis		☐ Rheumatoid Arthritis		☐ Prostate Removal	
☐ Emphysema		☐ Scleroderma		☐ Sigmoidoscopy	
☐ Epilepsy		☐ Seizure		☐ Thyroidectomy	
☐ Fall risk		☐ Stroke		☐ Tonsillectomy	
☐ GERD		☐ Thyroid Problems		☐ Tubal Ligation	
☐ Glaucoma		☐ TIA		☐ Vasectomy	
☐ Gout		☐ Ulcerative Colitis		☐ Wide Re-excision	
☐ Heart attack		☐ Upper Endoscopy		☐ Other- _____	
☐ Heart Disease		☐ Uterine Fibroids		☐ Other- _____	
☐ Heart Valve Disease		☐ Other-		☐ Other- _____	

Name: _____ Date of Birth: _____ Today's Date: _____

OB/GYN History

Pregnancies		Menstruation		Menopause
# of Pregnancies		Menses start age		☐ Yes Age of Onset?
# of Births		Last Menstrual Period		☐ No
Age at 1st birth		Menstrual Cycle Length		☐ Unknown
# of interrupted pregnancies				Menopause Reason? ☐ Surgical ☐ Natural
Hormone Use:				
☐ Contraception	# of years used			
☐ Post Menopause Use	# of years used			
☐ Other Hormone Use	# of years used & why?			

Family History of Cancer

Family 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		Alcohol	Substance/Products		
☐ Yes- Active	# of years:	☐ Yes- Active	☐ Cigarettes		
☐ Yes- Occasional	# of packs/day:	☐ Yes- Occasional	☐ Chewing Tobacco		
☐ Yes- But quit	Pack years:	☐ Yes- But quit	☐ Cigars	☐ Snuff	
☐ Never	Years Quit:	☐ Never	☐ Pipe	☐ Narcotics	
		# of Days/Week:	☐ Marijuana	☐ Illicit/Recreational Drugs	
		# of Drinks/Day:	☐ Liquor	☐ Beer	☐ Wine

Name: _____ Date of Birth: _____ Today's Date: _____

System Review Please check all that apply.***

Constitutional:	Allergies: (See list)	Head:	Eyes:	ENT:
☐ Loss or decrease of appetite	☐ Yes	☐ Alopecia (Hair Loss)	☐ Double or blurred vision	☐ Difficulty Swallowing (dysphagia)
☐ Fatigue	☐ No		☐ Weeping eye	☐ Difficulty Hearing
☐ Fever			☐ Night blindness	☐ Ear infections
☐ Lethargy			☐ Sensitive to light (Photosensitivity)	☐ Ear pain or Drainage
☐ Night sweats			☐ Contacts or Glasses	☐ Nosebleeds (epistaxis)
☐ Chills			☐ Eye Disease	☐ Sore/dry throat
☐ Recent unplanned weight loss? How much?			☐ Eye Injury	☐ Sinusitis
			☐ Blind- Which eye?	☐ Hearing Aids- which ear?
				☐ Mucus/Phlegm
				☐ Mouth sores
				☐ Ringing in Ears

Neck:	Integumentary (Skin):	Breasts:	Cardiovascular:	Respiratory:
☐ Masses	☐ Blisters	☐ Any lumps or swollen glands	☐ Arrhythmia	☐ Chronic daily or frequent cough
☐ Muscle weakness	☐ Bruising	☐ Nipple discharge	☐ Chest Pain	☐ Coughing up sputum Color?
☐ Pain	☐ Dry skin	☐ Nipple inversion	☐ Shortness of breath while walking	☐ Coughing up blood
☐ Range of Motion	☐ Facial burning	☐ Pain	☐ Swollen feet, ankles, or legs (Edema)	☐ Hiccoughs
☐ Swelling	☐ Nail Changes		☐ Shortness of breath while lying flat	☐ Pleuritic chest pain
	☐ Photosensitivity		☐ Palpitations	☐ Wheezing
	☐ Itching (Pruritus)			
	☐ Rash			
	☐ Hives			

Gastrointestinal:	Genitourinary:	Musculoskeletal:	Neurological:	Psychiatric:
☐ Abdominal Pain	☐ Painful Urination	☐ Arthritis	☐ Disorientation	☐ Delusions
☐ Bowel Frequency	☐ Frequency/Urgency	☐ Joint pain, stiffness, or swelling	☐ Abnormal Gait (Unsteady on Feet)	☐ Hallucinations
☐ Constipation	☐ Genital Masses	☐ Bone pain	☐ Dizziness	☐ Depression
☐ Frequent diarrhea	☐ Blood in Urine	☐ Muscle Weakness	☐ Headaches	☐ Euphoria
☐ Heart burn/GERD	☐ Incontinence	☐ Range of motion	☐ Insomnia	☐ Mood Swings
☐ Throwing up blood	☐ Nocturia		☐ Memory Loss	☐ Schizophrenia
☐ Rectal bleeding or blood in stool	☐ Renal stone disease		☐ Paralysis or weakness of one body side	
☐ Hemorrhoids	☐ Impotence		☐ Neuropathy- motor	
☐ Nausea	☐ Difficulty maintaining an Erection		☐ Numbness or tingling (sensory problems)	
☐ Cramping	☐ Urine color change		☐ Seizures	
☐ Fullness (satiety)	☐ Vaginal discharge		☐ Stroke	
☐ Vomitting	☐ Vaginal Spotting			

Endocrine:	Hematology:	Dermatology:
☐ Diabetes	☐ Easy bruising	☐ Rash or itching
☐ Hot flashes	☐ Swollen Lymph Nodes	☐ Skin Cancer
☐ Menstrual Irregularities	☐ Anemia	☐ Unusual Mole Changes/ New Mole
☐ Thyroid Disease		☐ Keloid

Name: _____ Date of Birth: _____ Today's Date: _____

HALIFAX HEALTH
CENTER FOR ONCOLOGY
UNIVERSAL MEDICATION FORM

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

List all medications you are currently taking (Prescription, over the counter, herbal, or supplements)

Name of Medication	Dose and Directions	Notes

Name: _____ Date of Birth: _____ Today's Date: _____

Halifax Health − Center for Oncology

At Halifax Medical Center	In Ormond Beach	In New Smyrna Beach	In Port Orange
303 N. Clyde Morris Blvd. Daytona Beach, FL	1688 W. Granada Blvd. Ormond Beach, FL	401 Palmetto St. New Smyrna Beach, FL	1185 Dunlawton Ave., Suite 105 Port Orange, FL
(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) 425-4214
Radiation Oncology Fax: (386) 425-7725
New Smyrna Beach Fax: (386) 424−5081

Patient Name _____ Medical Record # _____

Address _____ Phone # _____

Date of Birth _____ Date Information Needed ____/____/____ Mail____ Pick Up____ Fax # _____
(PHYS/FACILITY)

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.

ROC CONSENT

Halifax Health − Center for Oncology

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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:_____

American Cancer Society®

Cancer Resource Network

Please fax or email completed form to
1-877-428-2862

Service Referral Form

Your health care provider believes the services and information provided by the American Cancer Society could be valuable to you and your family in dealing with your cancer experience. Please expect a call from an American Cancer Society representative within 72 hours.

You will receive patient information, including information about the programs and services available through your American Cancer Society. In the meantime, if you have questions about your cancer or the American Cancer Society's services, we are available 24 hours a day, seven days a week. Please call 1.800.227.2345 or visit our Web site at cancer.org.

ALL INFORMATION WILL REMAIN CONFIDENTIAL.

I am interested in:

- ☐ Cancer information
- ☐ Patient support programs and services
- ☐ Transportation
- ☐ Lodging
- ☐ Other (please specify) _____

*Required fields

***Patient Name** _____

***Address** _____

***City** _____ ***State** _____ ***Zip** _____

***Preferred Phone** (___) _____ ***Okay to leave telephone message?** ☐ Yes ☐ No

Best time to call _____ **Email Address** _____

Gender ☐ Female ☐ Male **Primary Language** ☐ English ☐ Spanish ☐ Other _____

***Type of Cancer** _____ ***Date of Diagnosis** _____

***Type of Insurance** ☐ Private ☐ Medicare ☐ Medicaid ☐ Military Program ☐ Uninsured

Patient Signature (if applicable) _____ **Date** _____

***Referred by** _____ ***Phone** _____

Facility Name _____

American Cancer Society Programs

The American Cancer Society provides free, comprehensive patient services and programs designed to help your patients with their information, day-to-day living, and emotional support needs. Below are some of the programs we offer.

♥	**Reach to Recovery®** – Trained breast cancer survivors provide one-on-one support and education to individuals dealing with the emotional and physical effects of breast cancer.	✓	**Hope Lodge®** – Cancer patients who need treatment far from home sometimes face a problem: how to pay for a place to stay. The American Cancer Society may be able to help through our Hope Lodge program. Hope Lodges offer free, overnight housing for cancer patients while they are being treated for cancer. Our Hope Lodges offer a comfortable place where you can find support and friendship from others going through the same thing.
♥	**Look Good Feel Better®** – Licensed volunteer cosmetologists teach cancer patients techniques to help restore their appearance and self-image during chemotherapy and radiation.	✓	***"tlc"*™ magalog** – A magazine and catalog in one, *"tlc"* supports women dealing with hair loss and other physical effects of cancer treatment. The magalog offers a wide variety of affordable products, such as wigs, hats, and prostheses, through the privacy and convenience of mail order.
♥	**I Can Cope®** – This educational program for cancer patients and caregivers provides reliable information, peer support, and practical coping skills. Please visit cancer.org/onlineclasses for more information about this program.	♥	**Cancer Survivors Network℠** – Created by and for cancer survivors and their families, this "virtual" community is a welcoming, safe place for people to find hope and inspiration from others who have"been there." Services include pre-recorded discussions and personal stories from people with cancer and their loved ones, discussion boards, chat rooms, private and secure email, personal Web pages, an Expression Gallery, and more. All are available online at csn.cancer.org.
✓	**Transportation** – The Society provides assistance to help cancer patients get to and from their treatment appointments, including the Road to Recovery℠ program, where rides are provided by trained volunteer drivers.		

American Cancer Society®

We **save lives** and create more birthdays by helping you stay well, helping you get well, by finding cures, and by fighting back.

cancer.org | 1.800.227.2345

revised 4/9/13

Name: _____

Date of Birth: _____ Phone #:_____

Email Request

We are kindly requesting your email address to add to our system. Your email will be used for:

- Access to the Patient Portal
- Communication with your care team
- Tele-health appointments
- Invitations to Oncology events, programs and support groups

EMAIL: _____

**** Your email will not be sold. It will be used for internal use only.****

HALIFAX HEALTH

Welcome to the Center for Oncology

My name is Kim Davis and I am the Financial Counselor at Halifax Health Center for Oncology. As part of your care team, my role is to coordinate the financial aspects of your journey and help guide you through various financial assistance programs that may be available to you.

If you do not have insurance, I can assist by connecting you with any available resources. If you are insured, I can help to better explain your benefits, I can assist you with co-pays, deductibles, and link you to many different resources.

I would like to have an opportunity to meet with you and explore if I can be of assistance in any way. Please feel free to contact me at your earliest convenience at **386-425-4974**. My office is located on the first floor of the Grant Cancer Center for Hope Oncology Center at 303 N Clyde Morris Blvd, Daytona Beach.

Please ask our front desk team to connect you with my office or you can also reach me by email at: **Kim.Davis@halifax.org**. We are all here to help you.

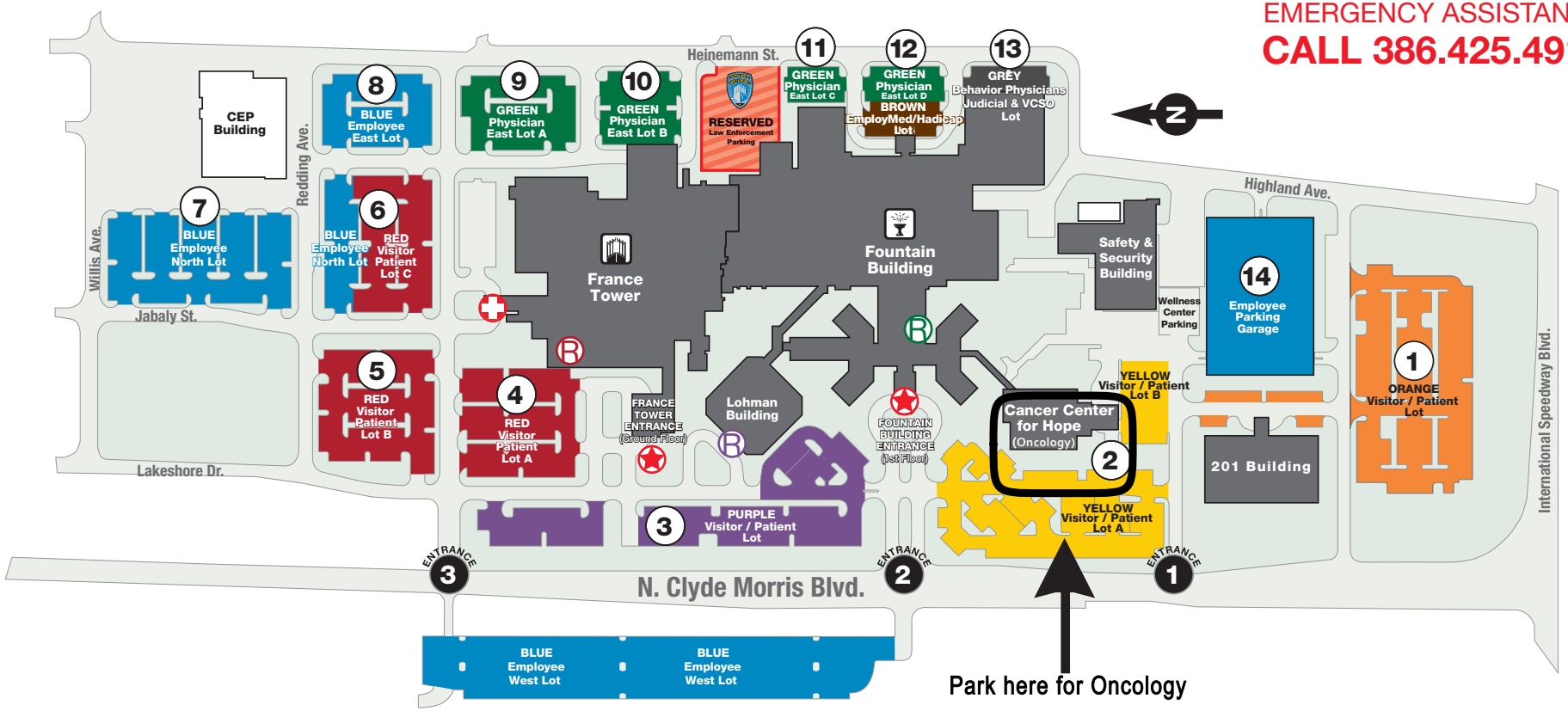
Thank you for your time, I hope to meet or hear from you soon.

Kind regards,

Kim Davis

Kim Davis
Financial Counselor
Patient Business & Financial Services

EMERGENCY ASSISTANCE
CALL 386.425.4911



Halifax Health Medical Center

303 N. Clyde Morris Blvd., Daytona Beach, FL 32114 • 386.425.4000

PATIENT AND VISITOR PARKING

LOT	BUILDING ACCESS	LOT	BUILDING ACCESS
1	201 Building	4 Lot A	**France Tower Registration** France Tower, Emergency Department
2 Lot A	**Fountain Building Registration, OB Registration,** Fountain Building, Cancer Center for Hope	5 Lot B	
2 Lot B	**Cancer Center for Hope** Reserved Parking, 8:00 am - 5:00 pm, Mon-Fri	6 Lot C	France Tower, Emergency Department
3	**Fountain Building Registration, Lohman Building Registration, OB Registration,** Fountain Building, France Tower, Lohman Building	12	Employee Health, Employmed, Team Member Handicap
		13	Behavior Physicians Judicial & VCSO

- Emergency Department Entrance
- Valet Service
- Lohman Building Registration
- Fountain Building Registration
- France Tower Registration

PHYSICIAN PARKING	
9 East Lot A	10 East Lot B
11 East Lot C	

EMPLOYEE PARKING		
6 7 North Lot	8 East Lot	14 Garage
West Lot located on west side of Clyde Morris Blvd.		

HALIFAX HEALTH

halifaxhealth.org

DO NOT PHOTOCOPY THIS DOCUMENT
Additional printed copies can be ordered from the Halifax Health Print Shop.

0409-0712