Place Label Here

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: ______________________________

DOB: ____/____/____ **Age:** __________ ❑ **Male** ❑ **Female** **SS#**: ______________________

Primary Address: ______________________________

City: ______________________ State:__________ Zip: __________

Home Phone: ❑ Preferred (______) ______________________

Cell Phone: ❑ Preferred (______) ______________________

Secondary Address: ______________________________

City: ______________________ State: __________ Zip: __________

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

May we send an SMS text message to your cell phone? ❑ Yes ❑ No

Email Address: ______________________ May we email you? ❑ Yes ❑ No

Preferred Language: ______________________

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: ______________________________

Pharmacy Phone # and Cross Streets:______________________________

(Internal Use Only)

MRN#: ______________

Patient Name: ______________________________ **DOB:** ______________

Primary Care Physician: ______________________________ Phone: ______________

Referring Physician (if different): ______________________________ Phone: ______________

Please list names of other physicians you see: (include phone #):

______________________________ Phone: ______________

______________________________ Phone: ______________

______________________________ Phone: ______________

______________________________ Phone: ______________

Emergency Contact Name:

____

Relationship: ______________________________ Phone: (______) ______________

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation): ______________________________

Name of Employer: ______________________________ Work Phone: (______) ______________

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

Patient Name: ____ **DOB:** ______________

Menstrual History (complete even if post-menopausal or no longer having periods)

1. Age at first period: _______ years.
2. If your menstrual periods are regular; periods start every ___________ days
3. lf your menstrual periods are irregular; periods start every ______ to _____ days (e.g.,12 to 60)
4. Duration of bleeding: ______ days
5. Does bleeding or spotting occur between periods? ❑ Yes ❑ No
6. Does bleeding or spotting occur after intercourse? ❑ Yes ❑ No
7. First day of last menstrual period ____
month day year
8. Is pain associated with periods? ❑ Yes ❑ No ❑ Occasionally
9. If yes to question 8, is it: ❑ Before menses? ❑ During menses? ❑ Both?

Pregnancy History (all pregnancies) **Have never been pregnant** ❑

10. Obstetrical history including abortions & ectopic (tubal) pregnancies

						Child		
Year	Place of delivery or abortion	Duration of pregnancy	Hours of labor	Type of delivery	Complications mother and/or infant	Sex	Birth weight	Present health

Birth Control History

11. What birth control method(s) do you currently use? ____

Patient Name: ______________________________ **DOB:** ______________

Sexual History

12. Do you have a sexual partner? ❑ Yes ❑ No (Male ❑ Female ❑)

13. Are there concerns about your sexual activity which you may want to discuss with your doctor? ❑ Yes ❑ No

Pap Smear/Mammogram History

14. Date of last pap smear: ______________________________

15. Have you ever had abnormal pap smears? ❑ Yes ❑ No

16. Have you had treatment for abnormal smears? ❑ Yes ❑ No

    If yes, what type(s) of treatment have you had? ❑ Cryotherapy ❑ Laser ❑ Cone biopsy ❑ Loop excision (LEEP)

    Year of treatment ________________

17. Date of last mammogram: ______________________________
    month year

18. Have you had an abnormal mammogram? ❑ Yes ❑ No

Other Past Gynecological History

19. Check any that apply:

None	❑	Venereal warts	❑	Herpes – genital	❑
Syphilis	❑	Pelvic inflammatory disease	❑	Endometriosis	❑
Chlamydia	❑	Gonorrhea	❑	Vaginal infections	❑
Other (specify)	❑				

____

Gynecologic Oncology
OF TALLAHASSEE
A Division of Florida Cancer Specialists

Patient Name: ______________________________ **DOB:** ______________

Reason for this visit: ______________________________

Medical History: Check the items that apply to you (current or past)

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

Other Medical History: ______________________________

Cancer History:

Type: ______________________________ Date diagnosed ____________

Treatment: (type, date and location of treatment) ______________________________

____

Treating Physician: ______________________________

Patient Name: ______________________________ **DOB:** ____________________

Past Obstetrical/Gynelogical Surgeries: (Please circle and date any of the surgeries and/or procedures that you have undergone)

D&C	Date: ________	Ovarian surgery	Date: ________
Hysteroscopy	Date: ________	L cyst(s) removed ovarian	Date: ________
Infertility surgery	Date: ________	R cyst(s) removed ovarian	Date: ________
Tuboplasty	Date: ________	L ovary removed	Date: ________
Tubal ligation	Date: ________	R ovary removed	Date: ________
Laparoscopy	Date: ________	Vaginal or bladder repair	Date: ________
Hysterectomy (vaginal)	Date: ________	for prolapsed or incontinence	
Hysterectomy (abdominal)	Date: ________	Cesarean section	Date: ________
Myomectomy	Date: ________	Other (specify)	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: ________
Prostate Operation	Date: ________	Prostatectomy	Date: ________
Hernia Repair	Date: ________	Appendectomy	Date: ________
Tonsillectomy	Date: ________	Hip Replacement	Date: ________
Mastectomy	Date: ________	Lumpectomy	Date: ________

Other Operations: ____

Patient Name: ____________________ **DOB:** ____________

Social History:

Tobacco Use: (Present and/or Past):

❑ Never Smoked

❑ Quit smoking When? _______ How many years did you smoke? _____yr(s)
How many packs? _____/day

❑ Currently Smoke ❑ Cigarettes ❑ Pipe ❑ Cigars How many packs? _____/day
How many years?_______

❑ Chewing Tobacco

Alcohol History: (Present and/or Past):

❑ 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

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other
Household Status: ❑ Lives Alone ❑ Lives with Family ❑ Lives in Nursing Home
❑ Winter Resident ❑ Year-Round Resident
Children: ❑ Yes ❑ No Number _____

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 Esophagogastroduodenoscopy (EGD) Date: ____________ Last Colonoscopy Date:_______

Last Prostate Exam Date: _______

Patient Name: ________________________________ **DOB:** ____________________

Review of Symptoms: (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

Cardiovascular:
- ❑ Chest Pain/Angina Pectoris
- ❑ Palpitations/Heart Murmur
- ❑ Irregular Heart Beat/Pressure

Respiratory:
- ❑ Chronic or Frequent Cough
- ❑ Bloody Sputum
- ❑ Shortness of Breath

Skin:
- ❑ Rashes or Itching
- ❑ Change in Skin Color or Moles
- ❑ Varicose Veins
- ❑ Skin Cancer

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 Stool
- ❑ Hidden Blood in Stool
- ❑ Excessive Rectal Gas/Flatus
- ❑ Loss of Stool/Fecal Accident
- ❑ Poor Appetite
- ❑ Jaundice

Genitourinary:
- ❑ Kidney Stones
- ❑ Pelvic Pain
- ❑ Incontinence
- ❑ Burning or Pain on Urination
- ❑ Blood in Urine
- ❑ Difficult Urination
- ❑ Men: Prostate Problems

Musculoskeletal:
- ❑ Joint Pain/Arthritis
- ❑ Muscle or Joint Weakness
- ❑ Back Pain
- ❑ Bone Pain
- ❑ Muscle Aches

Neurological:
- ❑ Numbness/Tingling
- ❑ Arm or Leg Weakness
- ❑ Light-Headed/Dizzy/Fainting Spells
- ❑ Tremors/Headaches

Psychiatric:
- ❑ Anxiety/Agitation
- ❑ Depression
- ❑ Crying for No Reason
- ❑ Insomnia
- ❑ Alcoholism
- ❑ Drug Problem

Hematologic:
- ❑ Easy Bruising
- ❑ Gum or Nose Bleeding
- ❑ Blood Transfusions

Endocrine:
- ❑ Heat or Cold Intolerance
- ❑ Excessive Skin Dryness
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Weight Problem
- ❑ Hot Flashes

Breast:
- ❑ Rashes or Itching
- ❑ Changes in Skin Color
- ❑ Varicose Veins
- ❑ Skin Cancer
- ❑ Breast Pain/Lump
- ❑ Breast Discharge
- ❑ Breast Rash

Allergies/Immunology:
- ❑ History of Allergies
- ❑ Chronic Infections

Patient Name: ______________________________ **DOB:** ______________

Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know. Relatives to consider: parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:

Ashkenazi Jewish ancestry? ❑ Yes ❑ No

Breast, ovarian, pancreatic cancer or metastatic prostate cancer diagnosed at any age? ❑ Yes ❑ No
If breast cancer, HER2 negative disease? ❑ Yes ❑ No

Colorectal or uterine (endometrial) cancer diagnosed at age 64 or younger? ❑ Yes ❑ No
OR, MSI high? ❑ Yes ❑ No
OR, Abnormal IHC? ❑ Yes ❑ No

20 or more colon/rectal polyps in your lifetime? ❑ Yes ❑ No

Do you have a family history of:

Breast cancer diagnosed at age 49 or younger? ❑ Yes ❑ No

Ovarian cancer diagnosed at any age? ❑ Yes ❑ No

Pancreatic cancer diagnosed at any age? ❑ Yes ❑ No

Uterine cancer diagnosed at age 49 or younger? ❑ Yes ❑ No

Colorectal cancer diagnosed at age 49 or younger? ❑ Yes ❑ No

Metastatic prostate cancer diagnosed at any age? ❑ Yes ❑ No

MEDICATION LIST

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

Drug Allergies: List all medication allergies

Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________

Are you allergic to:

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

Other: ____

Type of Reaction: ______________________________________

Gynecologic Oncology
OF TALLAHASSEE
A Division of Florida Cancer Specialists

Patient Name: ______________________________ **DOB:** ______________

CURRENT MEDICATION LIST

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

Medication	Dose	Frequency	Ordering Physician

Gynecologic Oncology
OF TALLAHASSEE
A Division of Florida Cancer Specialists

AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists (GOT/FCS), to take my photograph (digital camera/video may be used). These photos may then be placed in my GOT/FCS electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

____
Patient Name (Print)

____
Patient or Guarantor (Signature)

____
Date

REQUEST FOR RELEASE OF RECORDS

I, ____ , request a copy of my complete medical record from the office of:

____

____

Include name and address of practitioner

To be sent to Gynecologic Oncology of Tallahassee: *(Internal use)*

____

Address, City, State, Zip Code

____

Fax/Telephone Number

______ I give permission to release my medical records to the above listed person, company or medical facility.
I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Gynecologic Oncology of Tallahassee (GOT) to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_______DISCLAIMER: Not signing does not prevent me from receiving care.

____ ____________________

Patient Name (Print) Date

____

Patient Date of Birth

____ ____________________

Patient or Guarantor (Signature) Date

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: ____ **DOB:** ____________________

Please check one of the following:

______ **I give permission to the employees of Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists to disclose my Protected Health Information to me and the following individual(s):**

Name: ______________________________________ Relation: ______________ Phone: ____________

Name: ______________________________________ Relation: ______________ Phone: ____________

Name: ______________________________________ Relation: ______________ Phone: ____________

Name: ______________________________________ Relation: ______________ Phone: ____________

Name: ______________________________________ Relation: ______________ Phone: ____________

Name: ______________________________________ Relation: ______________ Phone: ____________

______ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

____ ______________

Patient Name (Print) Date

____

Patient or Guarantor (Signature)

Patient Name: ____________________ **DOB:** ____________________

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________

Name of primary policy holder: ____________________

Policy#/Group ID: ____________________

Policy holder's date of birth: ____________________ Policy holder's SS#: ____________________

Policy holder's employer: ____________________

Does plan have prescription coverage? ❑ Yes ❑ No

Secondary Insurance Carrier: ____________________

Name of secondary policy holder: ____________________

Policy#/Group ID: ____________________

Policy holder's date of birth: ____________________ Policy holder's SS#: ____________________

Policy holder's employer: ____________________

Does plan have prescription coverage? ❑ Yes ❑ No

Pharmacy Insurance Carrier: ____________________

Name of pharmacy policy holder: ____________________

Policy#/Bin# ____________________

I certify that the information provided is accurate. I will notify Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists, of any changes as soon as they become available. I understand that it is my responsibility to update the practice of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

____________________ ____________________
Patient Name (Print) Date

____
Patient or Guarantor (Signature)

FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

Thank you for choosing Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists (GOT/FCS), as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide GOT/FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that GOT/FCS will bill your insurance plan or program for services provided by GOT/FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to GOT/FCS and you are authorizing payment to be made directly to GOT/FCS.
- You agree you are responsible for payment to GOT/FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, GOT/FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of GOT/FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- GOT/FCS owns and operates RX To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your GOT/FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use RX To Go and may have your prescriptions filled wherever you choose. However, if you select RX To Go to fill GOT/FCS-issued prescriptions, then this policy and all other GOT/FCS patient financial responsibility policies will also apply to the items and services provided to you by RX To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by GOT/FCS clinicians at GOT/FCS's own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to GOT/FCS that results in a surplus on your account (i.e., a credit balance), GOT/FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and GOT/FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, GOT/FCS will refund the credit balance to you. However, you agree that any refund under $10 will be made only if you make a written request and, in any event, any credit balance under $10 will be forfeited if a refund request is not received within five years after the conclusion of your care.

Gynecologic Oncology
OF TALLAHASSEE
A Division of Florida Cancer Specialists

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.
A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST.**

____ _______________
Patient Name (Print) Date

____
Patient or Guarantor (Signature)

For office use:

____
Name (Print)

____
GOT/FCS Employee (Signature)

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

Name of Beneficiary: ____

Health Insurance Claim Number: ______________________________________

Medicare Beneficiary Identifier: ______________________________________

Medigap Policy Number: ____

I request that payment of authorized Medigap benefits be made on my behalf to Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists, or RX To Go for any services furnished by ______________________ ______________. I authorize any holder of medical information about me to release to ________________
Physician Name
______________ any information concerning this Medicare claim, because my signing this authorization will cause
Insurance Name
Medicare payment information to cross over automatically.

______________________________________ ______________
Patient Name (Print) Date

____
Patient or Guarantor (Signature)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists (GOT/FCS), Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any GOT/FCS facility or by submitting a request in writing to the corporate office at Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists, Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting **GYNONCofTally.com/policies/GOT_NPP.pdf**

Date:_______________

_______________________________________ _______________________
Patient Name (Print) DOB

_______________________________________ _______________________
Patient (Signature) Date

_______________________________________ _______________________
Patient or Guarantor (Signature) Date

By signing below, I authorize Gynecologic Oncology of Tallahassee, A division of Florida Cancer Specialists, (GOT/FCS) (and any authorized GOT/FCS texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by GOT/FCS under my cell phone plan.

I know that I am under no obligation to authorize GOT/FCS to send me text messages. I may opt-out of receiving these communications at any time by responding with “STOP”.

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

______________________________ ______________
Patient Name (Print) Date

____
Patient (Signature)