Community Cancer Center

Phone: (541) 673-2267 or Toll free (866) 836-4448

Appointment Date & Time:	Place Name Sticker Here
Referring Physician:	Primary Care Provider:

PATIENT HISTORY QUESTIONNAIRE ❑ Initial ❑ Re-Evaluation

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ African American ❒ Pacific Islander ❒ Caucasian ❒ Decline to Provide

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Decline to Provide **Preferred Language:** _____

ESCORT INFORMATION

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Significant Other

Spouse or Significant Other's name: _____

Who will accompany you on your first visit? Please provide name and relationship.

_____

Do you wish to have your escort included in your initial meeting with the physician? ❑ Yes ❑ No

May we discuss your medical diagnosis and treatment with your family? ❑ Yes ❑ No

Exclusions? ❑ Yes ❑ No _____

WORK HISTORY

Occupation: _____

Currently employed? ❑ Yes ❑ No Hours: _____

Has your illness forced you to stop working? ❑ Yes ❑ No Date: _____

Do you anticipate being off work? ❑ Yes ❑ No Date: _____

Has your illness forced significant other to stop working? ❑ Yes ❑ No Date: _____

PAST SURGERIES OR HOSPITALIZATIONS

List any and year performed. ❑ None

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

OTHER MEDICAL ILLNESSES OR CONDITIONS, CURRENT OR PAST (Heart disease, diabetes, etc.)

List any and year occurred. ❒ None

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Do you have a history of MRSA? ❑ Yes ❑ No Date: _____

Do you have any implanted devices (pacemaker, nerve stimulator)? ❑ Yes ❑ No List: _____

Have you had your flu vaccine this year? ❑ Yes ❑ No Date: _____

MEDICATIONS

❒ None Preferred Pharmacy: _____

List all current medications and doses including all over-the-counter, herbs, vitamins and non-prescription medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES: _____

Do you have a POLST or Advanced Directive? ❑ Yes ❑ No

Community Cancer Center

Place Name
Sticker Here

FAMILY HISTORY OF CANCER

Immediate		Type of Cancer	Maternal		Type of Cancer	Paternal		Type of Cancer
Mother	☐Yes		Grandmother	☐Yes		Grandmother	☐Yes	
Father	☐Yes		Grandfather	☐Yes		Grandfather	☐Yes	
Sister	☐Yes		Aunt	☐Yes		Aunt	☐Yes	
Brother	☐Yes		Uncle	☐Yes		Uncle	☐Yes	
Children	☐Yes							

FAMILY HISTORY

Please check the appropriate box if there is a history of the following disease(s) in your immediate family.

❒ Heart Disease ❒ High Blood Pressure ❒ Stroke ❒ Diabetes

List other hereditary diseases: _____

Mother ❒ Alive ❒ Deceased Cause: _____ Age: _____
Father ❒ Alive ❒ Deceased Cause: _____ Age: _____
Children #_____Alive #_____Well #_____Natural #_____Adopted ❑ Able to Assist

HISTORY OF TOBACCO, ALCOHOL, and EXPOSURES

Tobacco

Ever use tobacco? ❒ Yes ❒ No
Currently use tobacco? ❒ Yes ❒ No

How many packs per day? _____
What year started? _____
What year stopped? _____

If yes, check type(s):

❒ Cigarettes ❒ Chew
❒ Pipe ❒ Cigars
❒ Snuff

To be completed by Nurse:
Total Pack Years: _____

Alcohol

Ever use alcohol? ❒ Yes ❒ No
Currently use alcohol? ❒ Yes ❒ No

If yes, list type/amount? _____
What year started? _____
What year stopped? _____

CURRENT PROGRAMS

Are you participating in any chemical dependency programs? ❒ Yes ❒ No
If yes, ❒ Smoke Cessation program ❒ AA ❒ Other _____

Were you exposed to carcinogenic substances, asbestos? ❑ Yes ❑ No List: _____
Do you have a history of illegal drug use? ❑ Yes ❑ No List: _____

GENERAL HISTORY

Before my current illness, I would describe my overall health as:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

At the present time I feel:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

PAST CANCER HISTORY

Have you ever had any of the following?
❒ Prior Cancers ❒ Prior Radiation ❒ Prior Chemotherapy ❒ None Apply

Are you taking hormonal therapy (i.e., Tamoxifen, Lupron)? ❒ No ❒ Yes If yes, what? _____

What other doctors have you seen for your current diagnosis? _____

Community Cancer Center

Place Name
Sticker Here

REVIEW OF SYSTEMS: Please ✓ any of the items that apply to you or that you may be experiencing.

CHIEF COMPLAINT: Please explain in your own words, the reason you are here today.

_____

GENERAL HISTORY
Normal Weight:_____
❑ Recent Weight Loss
Amount:_____
❑ Recent Weight Gain
Amount:_____
❑ Loss of appetite
❑ Fatigue
❑ Weakness
❑ Fevers
❑ Chills
❑ Night sweats
❑ Sleep problems

EYES
❑ Glasses
❑ Contact Lenses
❑ Glaucoma
❑ Cataracts
❑ Double vision
❑ Change in vision
❑ Other vision problems

EARS/NOSE/THROAT
❑ Loss of hearing
❑ Hearing aid
❑ Ringing in ears
❑ Other ear problems
❑ Dentures
❑ Dental problems
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty swallowing
❑ Dry mouth
❑ Loss of taste
❑ Neck stiffness
❑ Neck pain or swelling

CARDIOVASCULAR
❑ Pacemaker
❑ Chest pain
❑ Irregular heartbeat
❑ Palpitations
❑ Hypertension
❑ Sleep sitting or propped up
❑ Short breath when lying down
❑ Fainting spells
❑ Leg pain while walking
❑ Swelling in feet
❑ Varicose veins
❑ Oxygen use at home

RESPIRATORY
❑ Shortness of breath
❑ Difficulty breathing
❑ Coughing
❑ Dry cough
❑ Coughing up sputum
❑ Coughing up blood

GASTROINTESTINAL
❑ Heartburn
❑ Nausea/upset stomach
❑ Abdominal pain
❑ Vomiting
❑ Jaundice
❑ Change in bowel habits
❑ Constipation
❑ Diarrhea
❑ Blood in stool
❑ Hemorrhoids/fissures
❑ Colonoscopy Date of Last: _____

GENITOURINARY
❑ Difficulty urinating
❑ Frequent urination
❑ Painful urination
❑ Up at night to pass urine
❑ Blood in urine
❑ Color change of urine

WOMEN ONLY
Age of Menarche ___ Age of Menopause ___
Date of last menstrual period: _____
Date of last pelvic exam: _____
Date of last pap: _____
❑ Abnormal vaginal bleeding
❑ Hot flashes
❑ Hormone therapy
❑ Currently sexually active
Is there a chance you may be pregnant?
❑ Yes ❑ No
____# of pregnancies ____# living

MEN ONLY
❑ Impotence
❑ Difficulty with erections
❑ Penile discharge
❑ Testicular mass
❑ Testicular pain

MUSCULOSKELETAL
❑ Leg cramps
❑ Painful muscles
❑ Painful joints
❑ Artificial joints
❑ Physical disabilities
❑ Gout

SKIN & BREAST
❑ Itching
❑ Blotchy
❑ Rash
❑ Scaling
❑ Sores
❑ Color changes
❑ Pain in breast
❑ Growths
❑ Lump or mass in breast or armpit
❑ Discharge or bleeding from nipple
❑ Change in nipple
❑ Nipple inversion
❑ Change in size, shape or contour of breast
❑ Mammogram Date of Last: _____

NEUROLOGICAL
❑ Headaches
❑ Tremors
❑ Memory loss
❑ Difficulty finding words
❑ Difficulty writing
❑ Difficulty thinking clearly
❑ Numbness or tingling
❑ Dizziness
❑ Loss of consciousness
❑ Seizures
❑ Coordination
❑ Unsteady gait

PSYCHIATRIC
❑ Nervousness
❑ Anxiety
❑ Depression
❑ Change in personality
❑ Relationship problems

ENDOCRINE
❑ Excessive thirst
❑ Excessive urination
❑ Thyroid problems

HEMATOLOGIC & LYMPHATIC
❑ Swollen lymph glands
❑ Excessive bruising
❑ Excessive bleeding

ALLERGY & IMMUNOLOGY
❑ Medications
❑ Latex allergies
❑ Food or non-medication allergies
❑ Tape allergies
❑ Hay Fever
❑ None

PAIN

Do you currently have any pain? ❒ Yes ❒ No If yes, where? _____

Please circle your current pain level on a scale of 0-10 (0 being no pain and 10 being the worst pain, or intolerable).

0	1	2	3	4	5	6	7	8	9	10

Do you take medication for this pain? ❒ Yes ❒ No List: _____
Is this medication effective for your pain? ❒ Yes ❒ No

Overall Health

Please mark on the scale below to demonstrate how you feel your overall health is today.

0 = Worst Imaginable Health State 100 = Best Imaginable Health State

0	10	20	30	40	50	60	70	80	90	100

Community Cancer Center

Place Name
Sticker Here

MOBILITY
❒ Independent
❒ Needs Assistance
❒ Transfers ❒ Cane
❒ Wheelchair ❒ Crutches
❒ Walker
❒ Bedbound
History of falls? ❒ Yes ❒ No

DAILY ACTIVITY
❒ Independent
❒ Needs Assistance
❒ Bathing
❒ Dressing
❒ Feeding
❒ Unable to perform

ANXIETY/DEPRESSION
❒ I am not anxious/depressed
❒ I am moderately anxious/depressed
❒ I am extremely anxious/depressed
❒ # hrs sleep per night _____
❒ # hrs sleep per day _____

FUNCTIONAL STATUS
Does patient exercise regularly? ❒ Yes ❒ No Type of exercise/frequency? _____
Does patient drive? ❒ Yes ❒ No Does patient have a vehicle available for transport? ❒ Yes ❒ No

NUTRITIONAL SCREEN

Without trying, have you lost or gained 10 pounds in the last 6 months?	❒ Yes	❒ No
Do you have an illness or condition that made you change the kind and/or amount of food you eat?	❒ Yes	❒ No
Do you eat at least 2 meals per day?	❒ Yes	❒ No
Do you eat at least 3 fruits or vegetables or 3 milk products per day?	❒ Yes	❒ No
Do you have 3 or more drinks of beer, liquor or wine almost every day?	❒ Yes	❒ No
Do you have tooth, mouth or swallowing problems that make it hard for you to eat?	❒ Yes	❒ No
Do you have enough money to buy the food you need?	❒ Yes	❒ No
Do you eat alone most of the time?	❒ Yes	❒ No
Do you take 3 or more different prescribed or over the counter medications per day?	❒ Yes	❒ No
Are you physically unable to shop, cook and/or feed yourself and have no one available to help?	❒ Yes	❒ No

CURRENT LIVING ARRANGEMENTS
❒ Live Alone ❒ Live with other(s) ❒ Assisted Living ❒ Nursing Home
Number living in house _____ Relationship(s) _____

What floor does patient live on? _____ Does the patient feel their living environment is safe? ❒ Yes ❒ No

Has the diagnosis of cancer forced a change in the patient's usual living situation? ❒ Yes ❒ No

Describe_____

PRINCIPAL SUPPORT PERSON
Name: _____ Health Issues of Principal Support Person That May Affect Care ❑ None

Describe: _____

EXTENDED FAMILY/FRIENDS SUPPORT (who would be available to drive, help around home if necessary)

_____

_____

OTHER SUPPORT RESOURCES (church, club affiliations, etc.)

_____

_____

❒ Senior Services ❒ Meals on Wheels ❒ Home Health or Hospice services ❒ Senior Companion
❒ Disability Service (Caseworker _____) ❒ Other: _____
Is your support system adequate to fit your needs? ❒ Yes ❒ No
Describe _____

Patient Signature _____ Date _____

Please list all vitamins/dietary supplements, with dosage and amount you currently taking

Name of dietary supplement .	Dosage mg or ml	Taking daily? weekly?

Patient name: _____ Date: _____

Community Cancer Center

Due to increased healthcare rules and regulations, please list all parties involved in your care or payment of care to which we may speak to or leave a message with regarding your healthcare, appointment scheduling, and payment.

Name	Relationship	Phone

Email: _____ (for access to patient portal) ❑ No Email

May we contact you at work? ❑ Yes ❑ No

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

Period for this consent is: ❑ From _____ to _____; **or**

❑ Lifetime or until notified

By signing below, I consent to Community Cancer Center's disclosure of information about my healthcare, appointments and payment to the above-named parties.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
for Community Cancer Foundation dba
COMMUNITY CANCER CENTER

Revision Date: April 17, 2017

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 the Privacy Officer of our office at (541) 673-2267.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
    - The Community Cancer Center participates in multiple internet-based health information exchanges. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may opt out and prevent searching of your health information available through the health information exchange by calling 541-673-2267, or completing and submitting an Opt-Out form to the Community Cancer Center, 2880 NW Stewart Parkway, Set 100, Roseburg, OR 97471.
- **To the Department of Health and Human Services (HHS)**. We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You**. We must disclose your medical information to you when you request it in writing, as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object**. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use**. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization**. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities**. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.
- **Law Enforcement**. We may disclose your Health Information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set**. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

- **Fundraising**. We may disclose certain medical information about you for fundraising purposes. We may also contact you for fundraising purposes. If you do not wish to be contacted for this purpose, you may opt out of receiving such communications.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information**. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other**. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.
  To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.
  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
  We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Patient Acknowledgement and Consent
for Health Information Disclosure, Evaluation, Treatment, and Billing

1. I understand that Community Cancer Foundation, dba Community Cancer Center and OHSU Department of Radiation Medicine (referred to below as "this Practice") will use and disclose **health information** about me as described in the **Notice of Privacy Practices** provided to me. I have received a copy of the **Notice of Privacy Practices** and have reviewed and understand the information included in it.

2. I grant permission for the Community Cancer Center and it's providers to evaluate and/or treat the above named patient.

3. I authorize this Practice to obtain prescription history information through the Pharmacy Benefit Manager. This monitoring allows the Practice to receive all current prescriptions that you have been prescribed by any of your providers within the last 12 months

4. I authorize payment to be made to this Practice for services provided.

5. **Copays are due at the time of service.** As a courtesy, we will bill your primary, and one secondary, insurance. However, **payment will be expected in full from the patient within 30 days after the patient's responsibility has been determined**, unless other payment arrangements have been made. If the provider is PARTICIPATING with my insurance carrier, I am only responsible for deductibles, co-insurance, and any non-covered services. If the provider is NON-PARTICIPATING with my insurance carrier, I am responsible for my account in full. Those patients undergoing radiation therapy will have individual financial counseling during their treatment period with estimated patient responsibility presented.

By signing below, I agree that I have reviewed and understand the information above.

By: _____ Date: _____
(Patient Signature)

_____
(Printed Name)

-OR-

By: _____ Date: _____
(Patient Representative)

_____
(Printed Name)

Description of Representative's Authority: _____