TMH PHYSICIAN PARTNERS

Welcome, on behalf of Tallahassee Memorial HealthCare, thank you for choosing us. We look forward to meeting and learning more about you during your first appointment.

In anticipation of your visit, we have included the following:

Welcome Letter
Advance Directive Letter
Patient Registration/Authorization and Agreement Form
Patient Profile
TMH Authorization for Release of Protected Health Information Form (highlighted areas only)
Tallahassee Memorial Cancer Center Stress Tetrameter
HIPAA Privacy

Please bring the included (completed) forms along with your current medications, insurance card(s), and a valid photo ID with you for your appointment. Also, please be sure to arrive **45 minutes** early to complete registration.

Our office will give a courtesy call for appointment reminders 48hrs in advance (please do not rely on this call in-case system is down). We do ask that if you need to cancel or reschedule appointment you give 24hr notice. If you No Show for appointment we will attempt to call you 3 times for reschedule. If we are unable to contact via phone we will send a reminder letter & contact your referring provider.

You may receive bills from TMH Physician Partners, Cancer & Hematology Specialists, Tallahassee Memorial Hospital, or other organizations for services provided such as office visits, lab tests, x-rays, treatments, etc. If you have questions about your bill, please call:

Sonia Lee, Office Manager
850-431-5360

Please be prepared to discuss and pay any possible co-pays, deductibles or co-insurance at each visit.

If you have any questions regarding any of the above information or your appointment, feel free to give us a call at 850-431-5360. We look forward to walking alongside you in this journey.

Thank you,

TMH Physician Partners - Cancer & Hematology Specialists

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PATIENT PROFILE

Health Maintenance:

Have you had a colonoscopy? ☐ NO ☐ YES; if yes when: ___/____/___ where: _____

Have you had a mammogram? ☐ NO ☐ YES; if yes when: ___/____/___ where: _____

Have you had a bone mineral density test (DEXA scan)? ☐ NO ☐ YES
if yes when: ____/____/____ where: _____

Are your immunizations current? ☐ NO ☐ YES; Date of last Tetanus: ____/____/____

Date of Flu vaccine: ____/____/____Date of Pneumonia vaccine: ____/____/____

Patient Health Questionnaire-2 (PHQ-2):

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Screening Questions:

Have you experienced 10 lbs weight loss or gain in past 3 months? ☐ NO ☐ YES

Do you have problems with mobility (use a wheelchair, cane, or walker)? ☐ NO ☐ YES;
if **YES** describe the problem and/or the device used_____

Have you had a fall in the past year? ☐ NO ☐ YES

Do you feel unsteady? ☐ NO ☐ YES

Are you in a relationship where you are being threatened or hurt? ☐ NO ☐ YES

Are there any religious considerations that would keep you from receiving blood products?
☐ NO ☐ YES

Contact Info

Patient Preferred Contact Number (_____) _____-_____

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May we leave a detailed message at this number? ☐ NO ☐ YES

REVIEW OF SYSTEMS: in the past 3 months, have you experienced any of the following:

CONSTITUTIONAL

Lack of appetite	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Lethargy/fatigue	☐ Yes	☐ No
Night sweats/chills	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No

How much?_____

HEAD/EYES

Hair Loss	☐ Yes	☐ No
Pain in Eye	☐ Yes	☐ No
Eye injury	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Blurry/Decreased Vision	☐ Yes	☐ No

EARS/NOSE /THROAT/NECK

Difficulty hearing	☐ Yes	☐ No
Ear aches	☐ Yes	☐ No
Buzzing or ringing in ears	☐ Yes	☐ No
Sensation of spinning	☐ Yes	☐ No
Recurrent sore throats	☐ Yes	☐ No
Persistent Hoarseness	☐ Yes	☐ No
Frequent Nosebleeds	☐ Yes	☐ No
Mouth Ulcers	☐ Yes	☐ No
Oral bleeding	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Swollen lymph nodes or glands	☐ Yes	☐ No

Where_____

Difficulty swallowing	☐ Yes	☐ No
Masses or lumps	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Altered taste	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No

SKIN

Chronic skin condition	☐ Yes	☐ No
Lump or growth on skin	☐ Yes	☐ No
Change in color of skin	☐ Yes	☐ No
Skin Tumors or moles	☐ Yes	☐ No
Rash	☐ Yes	☐ No

BREASTS

Masses or lumps	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No
Nipple inversion	☐ Yes	☐ No
Pain	☐ Yes	☐ No

HEART

Chest pain	☐ Yes	☐ No
Ankle swelling	☐ Yes	☐ No
Sleeping with head elevated	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Calf cramps with walking	☐ Yes	☐ No

LUNG

Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Blood in sputum	☐ Yes	☐ No
Wheezing/asthma	☐ Yes	☐ No
Infections/pneumonia	☐ Yes	☐ No

NEURO

Frequent or severe headaches	☐ Yes	☐ No
Dizziness or faintness	☐ Yes	☐ No
Nervousness/Anxiety	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Disorientation	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Abnormal gait	☐ Yes	☐ No

GASTROINTESTINAL

Nausea or vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea or frequent stools	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Blood in vomit	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Yellow skin/jaundice	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Decreased appetite	☐ Yes	☐ No
Change in stools	☐ Yes	☐ No
Black, tarry stools	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No

BONES AND MUSCLES

Painful joints	☐ Yes	☐ No
Sore muscles	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Decreased range of motion	☐ Yes	☐ No

ENDOCRINE

Hot flashes	☐ Yes	☐ No
Other endocrine diseases	☐ Yes	☐ No

Patient Name: _____ Date of Birth: _____

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HEMATOLOGIC/ LYMPH

Bruising	☐ Yes	☐ No
Enlarged lymph nodes	☐ Yes	☐ No

GENITOURINARY

Decreased size/force of urine stream	☐ Yes	☐ No
Increased frequency of urination	☐ Yes	☐ No
How often? _____		
Burning sensation during urination	☐ Yes	☐ No
Nighttime urination	☐ Yes	☐ No
How many times @ night _____		
Sensation that bladder cannot empty	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No

MEN ONLY

Erectile dysfunction	☐ Yes	☐ No

WOMEN ONLY

Vaginal Discharge or bleeding	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Painful Intercourse	☐ Yes	☐ No

PSYCHIATRIC

Delusions/Hallucinations	☐ Yes	☐ No
Mood swings	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Body Dysmorphic Disorder	☐ Yes	☐ No
Post-Traumatic Stress Syndrome	☐ Yes	☐ No
Paranoia	☐ Yes	☐ No
Bi-Polar	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No

GYN HISTORY:

Are you possibly pregnant now? □ Yes □ No

Are you in menopause? □ Yes □ No

Was your menopause □ natural □ surgical (hysterectomy)

Care Team:

Who referred you to our office? _____

Do you have a Primary Physician (Family Doctor) YES_____ or NO_____

Primary Physician Name: _____

Do you have a General Surgeon (Cancer Surgeon) YES_____ or NO_____

General Surgeon Name: _____

Do you have a Radiation Oncologist (Radiation Doctor) YES_____ or NO_____

Radiation Oncologist Name: _____

Do you have a Pulmonary Physician (Lung Doctor) YES_____ or NO_____

Pulmonary Physician Name: _____

Do you have a Neurology Physician (Nerve/Brain Doctor) YES_____ or NO_____

Neurology Physician Name: _____

Do you have a Dermatology Physician (Skin Doctor) YES_____ or NO_____

Dermatologist Physician Name: _____

Do you have a Urology Physician (Bladder Doctor) YES_____ or NO_____

Urology Physician Name: _____

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Do you have a Cardiology Physician (Heart Doctor) YES_____ or NO_____

Cardiology Physician Name: _____

Do you have a Gastroenterology Physician (Stomach Doctor) YES_____ or NO_____
Gastroenterology Physician Name: _____

Please list any other Physicians (Doctors) that you are seeing that you would like us to send your information to regarding your care.

_____ _____

_____ _____

_____ _____

ALLERGIES:

Please list any medications to which you are allergic. Include any reactions you have had to x-ray dyes (Iodine) or Shellfish.

_____ No known allergies

	Medication	Type of reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____

_____

MEDICATIONS/PHARMACY:

Preferred Pharmacy _____ Location _____

Medication List (medication from the prescription label)

Date	Drug Name	Dose	How often?	Why do you take medication?

Patient Name: _____ Date of Birth: _____

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PAST MEDICAL HISTORY:

Have you ever had any of the following? (Please check)

- ☐ Bone fracture after age 50
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Pacemaker/Defibrillator
- ☐ Blood Clots
- ☐ Heart Rhythm Disease
- ☐ Lupus
- ☐ Congestive Heart Failure
- ☐ Osteoarthritis
- ☐ Cirrhosis
- ☐ Heart Attack
- ☐ Emphysema or COPD
- ☐ Rheumatoid arthritis
- ☐ Colitis
- ☐ Seizures
- ☐ Long term steroid use greater than 6mon
- ☐ Coronary Artery Disease
- ☐ Asthma
- ☐ Stomach Ulcers
- ☐ Gallstones
- ☐ Acid Reflux Disease
- ☐ Clotting Problems
- ☐ Tuberculosis
- ☐ Pancreatitis
- ☐ Diverticulitis
- ☐ Thyroid
- ☐ Stroke
- ☐ Asbestos Exposure
- ☐ OTHER: _____

PREVIOUS SURGERY/PROCEDURE(S)

Date	Surgery/Procedure	Date	Surgery/Procedure

Patient Name: _____ Date of Birth: _____

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FAMILY HISTORY OF CANCER: GRANDPARENTS, MOTHER, FATHER, BROTHER, SISTER

Adopted? ☐ Yes ☐ No

Relative	Type of cancer	Age when diagnosed	Alive?

Family history of hip fracture ☐ No ☐ Yes if yes who? _____

ALCOHOL & TOBACCO USE:

Do you smoke cigarettes? ☐ Yes ☐ NO # packs per day: ___ for how many yrs?_____
Are you interested in stopping? _____

Have you ever smoked for period of ☐ Yes ☐ No # packs per day:_____ five or more years?
How many years? _____

Regular alcohol/beer intake ☐ Yes ☐ No Per Day? _____ Per Month? _____

SOCIAL HISTORY:

☐ Single ☐ Married Spouses Name:_____ ☐ Divorced
☐ Widow ☐ Widower

Do you live with someone? ☐ Yes ☐ No If, Yes who: _____
Number of Children: _____

Education: Check last year completed:
Grade School ☐ 1-5 ☐ 6- 8 High School ☐ 9 ☐ 10 ☐ 11 ☐ 12
College ☐ Masters ☐ Doctorate ☐

Occupation: Check one or more:
☐ Employed/Self-employed ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled
If employed, describe the work you do:_____

If retired, your occupation prior to retirement:_____

If disabled, describe disability and date work stopped:_____
_____

SOCIAL ISSUES:

Patient Name: _____ Date of Birth: _____

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If "Yes," Please explain

Do you have transportation issues? ☐ Yes ☐ No_____

Do you need assistance with your activities of daily living? ☐ Yes ☐ No_____

Do you have financial concerns? ☐ Yes ☐ No_____

Concerned about your coping abilities, or your family's ability to cope? Marital concerns? ☐ Yes ☐ No _____

Advance Directives

Do you have a Living Will? ☐ Yes ☐ No

If no, would you like information about how to establish a Living Will? ☐ Yes ☐ No
Do you have a Health Care Surrogate? ☐ Yes ☐ No
If yes, please provide the person/s name and phone number.
Name: _____ Number: _____

Information Release:

The physicians and staff of TMHPP Cancer and Hematology Specialists consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, tests results, and/or treatment plan. Please sign below indication you have given this authorization.

YOU MAY DISCUSS MY TREATMENT WITH:

Name	Relationship

Patient Name: _____ Date of Birth: _____

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Patient Name: _____ Date of Birth: _____