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. We hope to provide you with exceptional and individualized care.

In anticipation of your visit, we ask that you complete the enclosed forms ahead of time:

- TMHPP Gynecologic Oncology Specialists Patient Profile Form
- Patient Registration/Authorization and Agreement
- TMH Authorization for Release of Protected Health Information Form (highlighted areas only)
- HIPAA Privacy

It is important that these are complete before your visit.

Please also bring in your current medication bottles, insurance card(s), and a valid photo ID with you for your appointment. Also, please be sure to arrive 30 minutes early to complete registration.

Please be prepared to pay any possible co-pays, deductibles, or co-insurance at each visit. You may receive bills from TMHPP Gynecologic Oncology Specialist, 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) 431-4888

If you have any questions regarding any of the above information or your appointment, feel free to give us a call at (850) 431- 4888. We look forward to seeing you soon!

Thank you,

TMH Physician Partners - Gynecologic Oncology Specialists

TMH PHYSICIAN PARTNERS
GYNECOLOGIC ONCOLOGY SPECIALISTS

New Patient Profile

Name (Last, First): _____ Age: _____

Primary Care Physician (Name and Phone number or location): _____

Referring Physician (Name and Phone number or location): _____

Other Physicians (Name and Phone number or location): _____

Preferred Pharmacy Name:_____ Pharmacy Location_____

Primary Problem

What brings you to see us today? _____

When did this problem begin? _____

Have you had any of the following tests?

	Yes	When and Where
Abnormal biopsy	☐	
CT Scan	☐	
MRI Scan	☐	
PET Scan	☐	

Have you been diagnosed with cancer before?

Type of Cancer:	Where treated (Doctor, Hospital, City)	When (Dates)

PAST MEDICAL HISTORY:

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

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Abnormal Heart Rhythm
- ☐ Heart Murmur
- ☐ COPD
- ☐ OTHER: _____
- ☐ Stroke/TIA
- ☐ Vascular disease
- ☐ Seizures
- ☐ Hypothyroidism
- ☐ Neuropathy
- ☐ Blood Clots
- ☐ Lupus
- ☐ Heart disease
- ☐ Colitis/Diverticulitis
- ☐ Hyperthyroidism
- ☐ Rheumatoid arthritis

PREVIOUS SURGERIES:

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

Any implanted devices (pacemakers, pumps, etc.) □ Yes □No

Patient Name _____ Date of Birth_____

TMH PHYSICIAN PARTNERS
GYNECOLOGIC ONCOLOGY SPECIALISTS

MEDICATIONS: List any medications you are taking, including all vitamins and supplements.
Copy names and dosages of medication from the prescription label.

Name of Medication	How Often	Dosage (mgs / tablets)
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

ALLERGIES: ☐ No food or medication allergies

Food or Medication	What happens reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SUBSTANCE 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 five or more years? ☐ Yes ☐ No # packs per day:_____
How many years? _____Quit when?_____

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

ANY drug use ☐ Yes ☐ No Per Day? _____ Per Month? _____

FAMILY HISTORY OF CANCER: Adopted? ☐ Yes ☐ No

Relative	Type of cancer	Age when diagnosed	Alive?

GYN HISTORY: Are you possibly pregnant now? □ Yes □ No
Do you plan or desire to have children in the future? □ Yes □ No
Are you in menopause? □ Yes □ No

Number of Pregnancies: _____ Live births: _____ Vaginal births: _____ Cesarean births: _____

Last menstrual period: _____
Currently taking any hormonal therapy (vaginal/oral/patch/gel)? _____
Before this problem began, when was your last gyn exam: _____

Patient Name _____ Date of Birth_____

TMH
PHYSICIAN PARTNERS
GYNECOLOGIC ONCOLOGY SPECIALISTS

Before this problem began, when was your last pap: _____

Patient Name _____ Date of Birth_____

TMH PHYSICIAN PARTNERS
GYNECOLOGIC ONCOLOGY SPECIALISTS

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

CONSTITUTIONAL

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

HEAD/EYES/ EARS/NOSE /THROAT/NECK

Ringing in ears	☐ Yes	☐ No
Blurry/Decreased Vision	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Mouth Ulcers	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No
Swollen lymph nodes or glands	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Masses or lumps	☐ Yes	☐ No

SKIN

Chronic skin condition	☐ Yes	☐ No
Rash	☐ Yes	☐ No

BREAST

Breast Lump	☐ Yes	☐ No
Nipple Discharge or change	☐ Yes	☐ No
Breast color change	☐ Yes	☐ No
Breast pain	☐ Yes	☐ No
Armpit lump	☐ Yes	☐ No

CARDIOPULMONARY

Ankle swelling	☐ Yes	☐ No
Sleep with head elevated	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Short of breath when walking	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Blood in phlegm	☐ Yes	☐ No
Wheezing/asthma	☐ Yes	☐ No
Use CPAP at home	☐ Yes	☐ No
Use Oxygen at home	☐ Yes	☐ No

MOVEMENT/MUSCULOSKELETAL

Painful joints	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Decreased range of motion	☐ Yes	☐ No
Wheelchair, cane or walker	☐ Yes	☐ No

GASTROINTESTINAL

Nausea or vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea or frequent stools	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Yellow skin/jaundice	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

GENITOURINARY

Incontinence of urine	☐ Yes	☐ No
Incontinence of stool	☐ Yes	☐ No

ENDOCRINE

Hot flashes	☐ Yes	☐ No
Other endocrine problems	☐ Yes	☐ No

HEMATOLOGIC/ LYMPH

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

PSYCHIATRIC

Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Body Dysmorphic Disorder	☐ Yes	☐ No
Post Traumatic Stress Syndrome	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No

GYNECOLOGIC

Vaginal bleeding	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Vaginal dryness	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Painful Intercourse	☐ Yes	☐ No
Painful periods	☐ Yes	☐ No
Menopausal	☐ Yes	☐ No

NEURO

Frequent or severe headaches	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Patient Name _____ **Date of Birth**_____

TMH Physician Partners
GYNECOLOGIC ONCOLOGY SPECIALISTS

SCREENING QUESTIONS:

Have you lost interest in doing things that use to give you pleasure?
☐ Not at all ☐ several days ☐ more than half the day ☐ nearly every day

Have you experienced 10lbs 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

Have you had a colonoscopy? ☐ NO ☐ YES; if yes when: _____

Have you had a mammogram? ☐ NO ☐ YES; if yes when: _____

Are your immunizations current? ☐ NO ☐ YES Date of last Tetanus: _____

Date of Flu vaccine: _____ Date of Pneumonia vaccine: _____

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

SOCIAL HISTORY:

Highest Education level: _____
Do you live with someone? ☐ Yes ☐ No If, Yes who: _____

If employed (retired), describe the work you do (did): _____

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

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 _____

Have you ever been the subject of violence in your home? ☐ Yes ☐ No_____

Do you have a Living Will? ☐ Yes ☐ No

If no, would you like information about how to establish a Living Will? ☐ Yes ☐ No

Patient Name _____ Date of Birth _____

TMH Physician Partners
GYNECOLOGIC ONCOLOGY SPECIALISTS

Do you have a Legal Health Care Proxy? ☐ Yes ☐ No

If yes, please provide the person/s name and phone 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:

1._____ Relationship_____ 2._____Relationship_____

3. _____Relationship_____ 4._____Relationship_____

Signed: _____ Date: _____

Acknowledgment of Notice of Privacy Policy

I have received a copy of Tallahassee Memorial Healthcare's Notice of Privacy Policy.
I ☐ do not ☐ Do___ wish to make further restrictions on the use of my protected health information.

Additional restrictions: _____
Patient Signature: _____ Date _____

EMERGENCY NOTIFICATION:

_____ _____
NAME **PHONE NUMBER**

_____ _____
NAME **PHONE NUMBER**

Reviewed by: _____, RN Reviewed by: _____, MD

Date: _____Time _____ Date: _____Time _____

Patient Name _____ Date of Birth _____

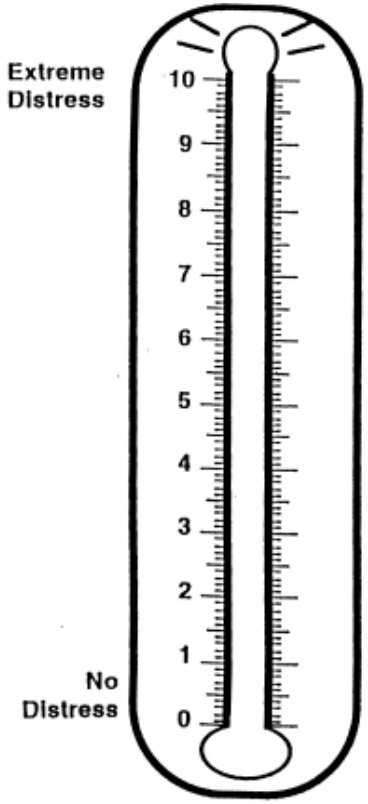
SCREENING TOOLS FOR MEASURING DISTRESS

Date: _____

Patient Name: _____ **Patient's Date of Birth: _____**

Patient's Signature: _____ **TMH Colleague:_____**

First, please circle the number (0-10) that best describes how much distress you have been experiencing in the past week, including today.



Secondly, please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check YES or no FOR each.

YES	NO	PRACTICAL PROBLEMS
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/school
		FAMILY PROBLEMS
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
		EMOTIONAL PROBLEMS
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**SPIRITUAL/RELIGIOUS CONCERNS**

YES	NO	PHYSICAL PROBLEMS
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/itchy
☐	☐	Sleep
☐	☐	Tingling in hands/feet

Other problems/comments _____

_____

_____

FAX TO 1687