PHYSICIAN PARTNERS
A TMH NETWORK

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)
Verbal Communication Authorizations
TMH 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 **30 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 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 seeing you soon!

Thank you,

Physician Partners - Cancer & Hematology Specialists

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PATIENT PROFILE

Date: _____ Sex: ☐ Male ☐ Female Age: _____

Name (Last, First): _____ Date of Birth: _____

Health Maintenance:

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

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

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

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

For office coding: _____*0*_____+_____+_____+____= *Total Score* _____

If scores 3 or greater – See PHQ9

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_____

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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

Patient Summary:

Emergency Contact Person (s) info

1. Name_____ Number_____ Relationship_____

2. Name_____ Number_____ Relationship_____

3. Name_____ Number_____ Relationship_____

Patient Communication Preference

☐ Printed Letter ☐ Phone Call ☐ Secure Email

Patient Preferred Contact Number _____ May leave a message ☐ Yes ☐ No

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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

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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

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

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

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

MEN ONLY
Erectile dysfunction (men only) ☐ Yes ☐ No

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

Patient Name: _____ Date of Birth: _____

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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 (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: _____

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. _____	_____

Patient Name: _____ Date of Birth: _____

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3. _____ _____

_____

MEDICATIONS/PHARMACY:

Preferred Pharmacy _____ Location _____

Medication List (medication from the prescription label)

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

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
- ☐ Long term steroid use greater than 6mon
- ☐ Colitis
- ☐ Seizures
- ☐ Coronary Artery Disease
- ☐ Asthma
- ☐ Stomach Ulcers
- ☐ Gallstones
- ☐ Acid Reflux Disease
- ☐ Clotting Problems
- ☐ Tuberculosis
- ☐ Pancreatitis
- ☐ Diverticulitis
- ☐ Thyroid
- ☐ Stroke

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☐ Asbestos Exposure
☐OTHER: _____

PREVIOUS SURGERY/PROCEDURE(S)

Date	Surgery/Procedure	Date	Surgery/Procedure

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? _____

FAMILY HISTORY OF CANCER:

Adopted? ☐ Yes ☐ No

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

Relative	Type of cancer	Age when diagnosed	Alive?

Patient Name: _____ Date of Birth: _____

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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:

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

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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

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/Time_____

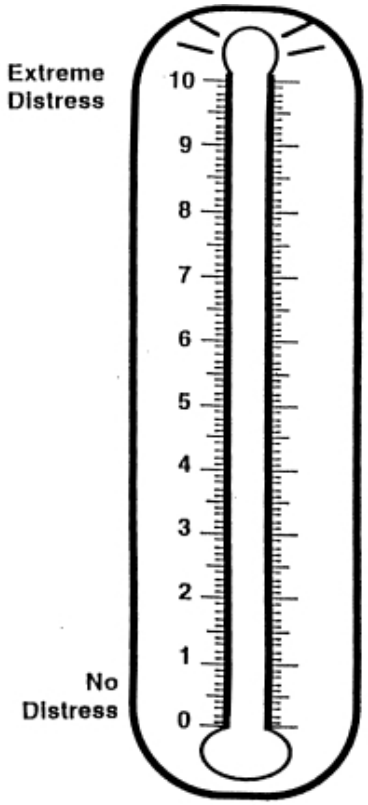
SCREENING TOOLS FOR MEASURING DISTRESS

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

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