TMH
PHYSICIAN PARTNERS
GYNECOLOGIC ONCOLOGY SPECIALISTS

**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,

Gynecologic Oncology Specialists

Tallahassee Memorial Hospital Physician Partners

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**_____________

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**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**______________

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

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**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**_____________

## 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 ____________

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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 ______________

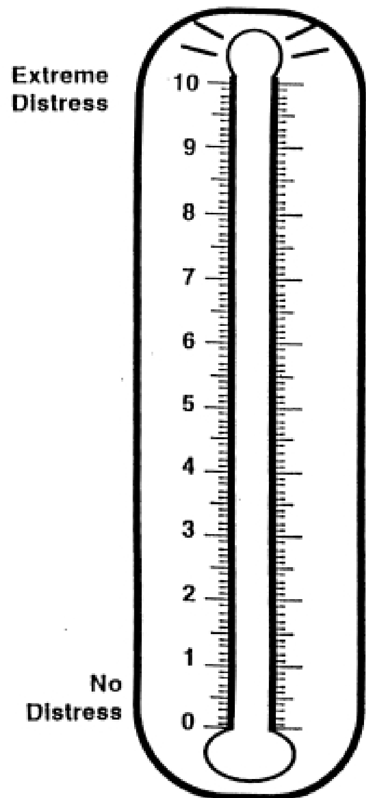
## SCREENING TOOLS FOR MEASURING DISTRESS

**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**______________________________________________

______________________________________________

______________________________________________

**Adapted with permission from the NCCN 1.2010** *Distress Management* Clinical Practice Guidelines in Oncology.
© National Comprehensive Cancer Network, 2010. Available at: http://www.nccn.org. Accessed 10/3/2010.
To view the most recent and complete version of the guideline, go online to www.nccn.org.

FAX TO 1687