



Welcome to Northwest Oncology and Hematology
and thank you for choosing us for your care.

BRUCE B. BANK, MD
APOORVA CHAWLA, MD
ELIZABETH ELLIOTT, DO
GARY S. GORDON, MD
GARY I. GRAD, MD
STEVEN L. KANTER, MD
GARY E. KAY, MD
KEVIN P. MCKIAN, MD
MARINA MESSINGER, MD
ROBERTO MONTAÑA, MD
ANITA PANDEY, MD
EDWIN R. PRIEST, MD
RONALD J. SHADE, MD
ALKARIM TAJUDDIN, MD, MBA
LAI XU, MD, PHD
EROL YORULMAZOGU, MD

To expedite the check in process for your first visit, please complete the attached new patient packet. The completed forms should be brought with you to your first appointment.

Please arrive at least **20 minutes prior** to your scheduled appointment to complete the registration process.

If you have any questions prior to your first visit, please do not hesitate to contact the **New Patient Coordinator at 847.577.0620 x7112.**

[Visit us on our Website: NorthwestOncology.com where you will find:](http://NorthwestOncology.com)

**ADVANCED CARE
& TREATMENT FOR:**

- Lung cancer
- Prostate cancer
- Breast cancer
- Gynecologic cancers
- Colon cancer
- Bladder cancer
- Kidney cancer
- Liver cancer
- Head & neck cancers
- Esophageal cancer
- Leukemia & blood cancer
- Lymphoma
- Sarcoma
- Anemia & blood diseases/disorders

**YOUR COMFORT
& CONVENIENCE**

- Serene, comfortable environment
- Same-day & next-day appointments
- Early morning appointments
- Infusion therapy
- Most insurance accepted & filed
- Payment plans available
- Oral dispensing service for chemotherapy & supportive drugs

3701 Algonquin Rd., Crossroads Center, Ste. 900
Rolling Meadows, IL 60008

Call: 847.870.4100 • Fax: 847.870.0866

800 Biesterfield Rd., Cancer Institute, Ste. 210
Elk Grove Village, IL 60007

Call: 847.437.3312 • Fax: 847.956.5107

1555 Barrington Rd., Doctors Bldg. 3, Ste. 1200
Hoffman Estates, IL 60169

Call: 847.885.4100 • Fax: 847.885.4199

27750 West Hwy. 22, Ste G70
Barrington, IL 60010

Call: 847.842.0180 • Fax: 847.842.9877

1435 N. Randall Road, Suite 501
Elgin, IL 60123

Call: 847.577.1023 • Fax: 847.717.0166

www.NorthwestOncology.com

Physicians and Services Information

Locations with maps

You will receive login information for *CareSpace* at your first visit.

CareSpace is found on our website and gives our patients online access to limited portions of their *Northwest Oncology and Hematology* patient chart. Accessible information includes:

- Certain lab results from blood that is drawn in our office
- Your current demographic information including your address and phone numbers, insurance information, and other physicians included in your care
- A summary page that includes current allergies, oncology and hematology diagnoses, and current medication list
- A calendar showing your scheduled visits
- A list of recorded vital signs
- A resource page including educational sites for different diagnoses

Patient Satisfaction Survey - We value your opinion. After your visit, please complete our *Patient Satisfaction Survey*, found on our website.



Northwest Oncology & Hematology, S.C.

Financial/Authorization Policy

Our Mission: The physicians, nurses and staff at Northwest Oncology & Hematology strive to provide the highest quality, individualized care for our patients in a compassionate, attentive manner. It is our mission to provide up to date care in an environment that comforts our patients and their families, respects their individual needs and wishes, and preserves their dignity.

We understand this may be a difficult and stressful time for you and your family. Our well-experienced staff will help to answer any questions you have regarding your insurance. Should you require chemotherapy treatment or require imaging services or tests, we will verify your insurance benefits and review the information obtained from your insurance carrier with you. A statement of estimate of financial liability, if any, will be discussed with you at this time.

Please take the time and carefully review how we will partner with you in understanding your financial responsibility, authorization policy and other information you may find helpful. A signature and date is required at the end of this form to serve as acknowledgment and authorization of our policies and procedures described herein.

INSURANCE

Claim Submissions

As a service to our patients, we will file claims to your primary and secondary insurance on your behalf. However, the insurance contracts are between you and your insurance company and you are ultimately responsible to see that your claims are paid in a timely manner.

Insurance Changes

It is your responsibility to notify us immediately regarding any changes in your insurance coverage. This is imperative because most insurance companies have “timely filing” rules, which if missed, will result in denial and non-payment of submitted claims. If this should happen, the full amount billed will become your responsibility to pay. In order to avoid this situation and other similar situations, please contact us as soon as possible with any changes and/or updates to your coverage. If your insurance application is pending with Illinois Department of Public Aid (IDPA) for example, please let us know so we can work with you to expedite the processing of this application.

Medicare – Our physicians are participating providers with Medicare and accept assignment on all covered claims. Medicare requires you to pay the 20% co-insurance and your annual deductible. If you have a secondary (supplemental) insurance, we will file claims to them on your behalf. Medicare reimburses for chemotherapy drugs based on patient diagnosis. If we suspect that Medicare may not cover part of your treatment for your diagnosis, you will be asked to sign an ABN (Advanced Beneficiary Notification) form, which will indicate acknowledgment that you have been informed that part of your treatment may not be covered. We will also work with you to find alternate sources of reimbursement for that part of your treatment that is not covered; for example, the use of a secondary insurance prescription plan or a drug company’s patient assistance program.



Financial/Authorization Policy

Medicaid – Our physicians are participating providers with the Illinois Department of Public Aid (IDPA). Claims will be filed on your behalf with a valid IDPA card that shows your eligibility. A valid IDPA card must be presented at the time of service. Services not covered by IDPA, such as spend down amounts, are your responsibility and payment is expected at the time of service.

Managed Care – Our physicians participate in many different plans and although our staff is knowledgeable about many of these, it is ultimately your responsibility to know. Well before you come in for your appointment, please contact your insurance company and verify that your particular plan is one in which we participate. Insurance company websites do not always contain accurate, up-to-date information, so please contact them by telephone instead. Also, please be sure to verify that diagnostic testing will be covered and what facility tests should be directed to (i.e. Quest Labs).

Commercial/Indemnity Plans – Our physicians participate in all of these plans. These plans generally have an annual deductible and an out-of-pocket expense up to a certain dollar amount. These expenses and deductibles are the patient responsibility and are expected at the time of statement.

Co-payments – A co-payment is a fixed amount of money you are required to pay to the provider, facility, pharmacy, etc., when you receive certain services. Co-payments must be paid at the time of service. Your HMO/PPO/POS plan will require that you pay a co-payment when you see your physician, when you have chemotherapy, when you have a port flush, when you have blood drawn, injections, and/or other imaging services/procedures. Please consult your insurance plan for specific coverage information and be prepared to pay this co-payment at the time of service.

Deductibles – A deductible is a fixed amount of expenses you must pay for certain covered services and supplies before your insurance company starts paying benefits for them. Co-payments and coinsurances do not count toward your deductible. If we verify that a deductible or a portion of your deductible has not been met and we verify that your insurance will cover and allow for payment of services rendered, we will ask for the appropriate portion of your deductible to be paid at the time of service. We can make exceptions to this policy if you can provide us with proof from your insurance company that your deductible has been met for the appropriate calendar year.

Coinsurance – A coinsurance is the percentage of your insurance plan allowance that you are responsible to pay for care. Coinsurance amounts are due and payable at time of statement.

Co-payments, Deductibles & Coinsurance – To summarize, co-payments, deductibles and coinsurance represent your contracted portion and financial obligation for services rendered to you. Routine waiver of co-payments, deductibles and coinsurance is considered “misstating the fee for services rendered” and may violate federal, state and local laws and regulations such as the False Claims Act, Anti Kick-back Statutes and compliance guidelines for individual and small group physician practices as well as insurance company/participating physician contracts.

Pharmacy Cards – Please inform us if you have a pharmacy card. Certain insurance carriers require certain injectables (drugs) to be obtained from outside sources as opposed to being obtained directly through our office. Therefore, in order to prevent any unnecessary patient financial responsibility, please provide us with this information.



Northwest Oncology & Hematology, S.C.

Financial/Authorization Policy

Referrals – Your Insurance Plan may have specific requirements for referrals to see a physician for diagnostic testing and/or treatments. Please review your particular insurance plan or call your insurance for those requirements. It is your responsibility to ensure that a referral is in place prior to your visit. Patients must present with a valid referral for covered services. Patients will not be seen without the referral. If a patient comes in without a referral, it may be necessary to reschedule the appointment. We will be happy to assist you with obtaining the referral. If the referral is for a series of treatments, which require numerous visits, it is your responsibility to ensure that the referral covers the appropriate number of visits and it is your responsibility to keep track of the number of visits used and the expiration date of the referral. Should you have any questions about this information, please speak with the receptionist at the front desk.

Laboratory – Your insurance plan may have specific rules about where your labs can be drawn. Most plans will only allow a drawing of a CBC (complete blood count) in our office. Some plans only allow CBC draws on days when chemotherapy treatment is also given. Some policies require your labs to be drawn at your PCP (Primary Care Physician) office or at a designated hospital or drawing facility. We hold a contract with Quest Laboratory, which allows us to draw and send out other lab tests; however, the types of tests allowed via this process vary depending on the particular insurance policy. Therefore, please review your policy and obtain accurate information by calling your insurance plan. **We will not be responsible for lab tests processed in an incorrect facility and you will be held accountable for any monies due as a result.**

Hospital Admissions – In the event a hospital stay is needed, please let your physician know which hospital is in your insurance plan network. Your insurance policy will most likely require pre-certification prior to your admission and this information will speed up that process.

Billing and Statements – Any questions concerning your billing statement can be answered by our staff at our Central Billing Office at 847-577-0620, Monday through Friday from 9:00 am – 4:00 pm. Each patient account is assigned and managed by one staff member according to the physician that patient sees. This ensures that you will always speak with the same highly competent specialist regarding your account. This design emphasizes our mission goal, to serve each person individually and to the best of our ability by allowing one particular specialist to familiarize themselves with your account and circumstance. Our staff may need to contact you regarding your account for various reasons; therefore, by signing the acknowledgement of receipt of this Financial/Authorization Policy form, you hereby authorize the staff at Northwest Oncology & Hematology to contact you and/or leave a message on voicemail, answering machine or other electronic device or with a person who answers the phone in regards to your appointments, administrative and/or financial obligations to this practice. You will sign a separate form regarding authorization to contact you and/or others regarding your health and any other health-related issues. We reserve the right to charge an administrative fee to help cover costs incurred in the effort to collect on delinquent accounts and also reserve the right to forward delinquent accounts to an outside collection agency should in-house attempts prove unsuccessful. Therefore, we encourage you to make every effort to keep in touch with us regarding the status of your outstanding account.

3701 Algonquin Road, Crossroads Center, Suite 900 • Rolling Meadows, IL 60008 • P/847.870.4100 • F/847.870.0866
800 Biesterfield Road, Cancer Institute, Suite 210 • Elk Grove Village, IL 60007 • P/847.437.3312 • F/847.956.5107
1555 Barrington Road, Doctors Building 3, Suite 1200 • Hoffman Estates, IL 60169 • P/847.885.4100 • F/847.885.4199
27750 W. Highway 22, Suite G70 • Barrington, IL 60010 • P/847.842.0180 • F/847.842.9877
1435 N. Randall Road, Suite 501 • Elgin, IL 60123 • P/847.577.1023 • F/847.717.0166



Northwest Oncology & Hematology, S.C.

Notice of Privacy Practices Acknowledgment of Receipt

Patient Name: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Northwest Oncology & Hematology, S.C.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Assignment of Benefits

I hereby authorize the release of any medical and other information necessary to insurance companies or associations, employee groups, government agencies or their third party payers and their agents/employees, adjusters and/or attorney's involved in my case, either electronically, by mail, fax or courier, as pertaining to my care in order to process my claims.

I also hereby authorize payment of medical/hospital benefits provided to me and submitted to my insurance company(ies) on my behalf to be paid directly to Northwest Oncology & Hematology, S.C.

If my insurance policy prohibits direct payment to doctor, I hereby instruct and direct my insurance company to do the following for any allowable benefit amounts billed by Northwest Oncology & Hematology and submitted on my behalf: Make the benefit check payable to "my name" and mail it to attention of my name "in care of" to the address as follows:

**c/o Northwest Oncology & Hematology, S.C.
3701 Algonquin Road, Suite 900
Rolling Meadows, IL 60008**

This is a direct assignment of my rights and benefits under this policy.
A photocopy of this Assignment shall be considered as effective and valid as the original.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Financial/Authorization Policy Form Acknowledgment of Receipt

I hereby certify that I have received a copy of the Financial/Authorization Form of Northwest Oncology & Hematology, S.C. I also hereby certify that I have read and understand the information and policies contained therein and duly authorize Northwest Oncology & Hematology, S.C. to execute the enclosed policies and its terms.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Northwest Oncology & Hematology, S.C.#

Patient Name: _____ Date of Birth: _____

We are mandated by the government and the Health Information Technology for Economic and Clinical Health (HITECH) Act to ask certain questions and have the information available in our Electronic Medical Records System (EMR). The HITECH Act provides the Department of Health and Human Services (HHS) with the authority to establish programs to improve healthcare quality, safety and efficiency through the promotion of health information technology (HIT), including electronic health records and private and secure electronic health information exchange. Please fill out the following form and return it to the front desk so your answers can be entered into our EMR system.

Ethnicity *(please circle any that apply)*

Hispanic or Latino

Not Hispanic or Latino

Race *(please circle any that apply)*

American Indian or Alaska Native

Caucasian

Asian

Native Hawaiian or Other Pacific Islander

Black or African American

Other

Preferred Language *(please circle any that apply)*

Chinese

Polish

English

Portuguese

French

Russian

Italian

Spanish

Japanese

Vietnamese

Korean

Preferred Method of Contact *(please circle one)*

Mail

Telephone: Home Work Cell



Northwest Oncology & Hematology, S.C.

Communication Policy and Waiver

Communication is a very important part of providing quality healthcare. In an effort to provide you with information regarding your healthcare, we ask that you complete this waiver. **This form will remain active until a request by the patient is made to have information changed or removed.**

We normally contact our patients between 8:00 am and 5:00 pm. Please provide the phone number that we should use to contact you during this period.

_____ Home Work Cell (please circle one)

If we need to reach you outside these hours, what is the phone number that we should use to contact you?

_____ Home Work Cell (please circle one)

Please list any additional phone numbers we may use to contact you:

_____ Home Work Cell (please circle one)

_____ Home Work Cell (please circle one)

I authorize the following people to receive medical information regarding my care:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize the following person to discuss financial information regarding my account:

Name	Relationship	Contact Number
_____	_____	_____

Do you have voicemail or an answering machine? Yes No (please circle)

May we leave **medical information** on your voicemail or answering machine? Yes No (please circle)

Print Name

Signature

Date

Recently enacted Federal laws protecting a patient's privacy prevent us from sharing any information about your medical condition without your authorization. If you would like us to release information to anyone other than your physicians that are treating you or your insurance company, please ask to sign a separate authorization.



Patient History

Name: _____ Date of Birth: _____

Social History

Marital Status: Single Married Domestic partner Divorced Widowed
Do you have children? Yes No If yes, how many children? _____

Occupation (previous, if retired): _____ Retire

Do you have an Advance Directive? Yes No

Is there a person who you would like to be your primary contact regarding your healthcare? Yes No
If yes, Name/Relationship: _____ Phone: _____

Do you currently use tobacco products: Yes No

Use per day: Cigarettes: _____ Cigars: _____ Pipe: _____ Chewing Tobacco: _____ E-Cigs: _____
For how many years have you used the above tobacco product? _____

Have you ever used tobacco products in the past? Yes No

If yes, use per day: Cigarettes: _____ Cigars: _____ Pipe: _____ Chewing Tobacco: _____ E-Cigs: _____
When did you quit? _____ For how many years did you use the above tobacco product? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____
Do you have a history of alcoholism? Yes No

Have you used illegal drugs? Yes No If yes, which ones? _____

Do you use marijuana? Yes No

Are you currently sexually active? Yes No

Travel History: Have you traveled outside the US in the past 6 months? Yes No
If yes, what countries? _____

Surgical History

Please list all operations and dates of operations:

1	5
2	6
3	7
4	8



Past and Present Medical Problems

Name: _____ Date of Birth: _____

Check all items either Yes or No and give approximate date if past:

	No	Yes Now	Yes Past	Past Date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (type)				
Arthritis				
Blindness - either eye				
Broken bones				
Cataracts				
Chronic Bronchitis/Lung Disease				
Cirrhosis of liver				
Colon or bowel trouble				
Deafness				
Diabetes Mellitus				
Dysentery				
Ear infections				
Emphysema				
Enlarged heart				
Glaucoma				
Gall stones				
Gout				
Goiter				
Gonorrhea				
Hay fever				
Heart murmur as adult				
Heart attack				
High blood pressure				
Hepatitis				
Hemorrhoids				
Kidney infection				
Kidney stones				
Nervous breakdown				
Poor blood clotting				
Polio				
Phlebitis				
Rheumatic fever				
Rectal trouble				

	No	Yes Now	Yes Past	Past Date
Recurrent boils				
Stroke				
Stomach or Duodenal ulcer				
Syphilis				
Skin Disease				
Serious depression				
Serious emotional problems				
Tuberculosis				
Thyroid (overactive)				
Thyroid (under active)				
Varicose veins				

Men

	No	Yes Now	Yes Past	Past Date
Prostate problems				

Women

	No	Yes Now	Yes Past	Past Date
Menstrual difficulties				
Cystitis				
Mastitis				
Ovarian cyst				
Breast cancer				
Other breast disease				
Still menstruating?				
Age period started:				
Age period stopped:				
Why period stopped:				
Number of pregnancies:				
Number of children:				
Number of miscarriages:				
Explain:				
Date of last mammogram:				



Current Symptoms

Name: _____ Date of Birth: _____

Symptoms: Please check all that apply or NONE.

Do you have pain? Yes No

If yes, where: _____ Intensity (1-10): _____ Frequency: _____

<p>GENERAL: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Change in weight</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Generalized weakness</p> <p><input type="checkbox"/> Frequent colds</p> <p>EYES: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Change in vision</p> <p><input type="checkbox"/> Eye pain</p> <p>EARS, NOSE, MOUTH and THROAT: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Hearing problems / loss</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Trouble swallowing</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Nasal drainage</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Dental problems</p> <p><input type="checkbox"/> Post nasal drip</p> <p><input type="checkbox"/> Sinus trouble</p> <p>HEART: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Heart palpitations</p> <p><input type="checkbox"/> Light headedness</p> <p><input type="checkbox"/> Swollen feet, ankle or hands</p> <p><input type="checkbox"/> Murmur</p> <p>LUNGS: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Sputum production</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Difficulty breathing when flat</p>	<p>ENDOCRINE: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Hot & cold intolerance</p> <p>DIGESTIVE: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Bowel incontinence</p> <p><input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Black stools</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Frequent heartburn</p> <p><input type="checkbox"/> Belching or excess gas</p> <p>GENITOURINARY: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Burning with urination</p> <p><input type="checkbox"/> Pain with urination</p> <p><input type="checkbox"/> Blood in the urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Urinary incontinence</p> <p><input type="checkbox"/> Excessive urination day/night</p> <p><input type="checkbox"/> Slow starting or stopping</p> <p><input type="checkbox"/> Unable to hold urine</p> <p>MEN ONLY...</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Prostate infections</p> <p>WOMEN ONLY...</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge or bleeding</p> <p>BONES, JOINTS, MUSCLES: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Muscle Pain <input type="checkbox"/> Bone pain</p>	<p>SKIN: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Nail changes</p> <p><input type="checkbox"/> Changes to palms of hands or soles of feet</p> <p><input type="checkbox"/> Change in mole or wart</p> <p><input type="checkbox"/> A sore that won't heal</p> <p><input type="checkbox"/> Other skin complaints</p> <p>NERVOUS SYSTEM: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Weakness of arms or legs</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Thinking difficulty</p> <p><input type="checkbox"/> Numbness in arms or legs</p> <p><input type="checkbox"/> Fainting</p> <p>PSYCHIATRIC: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Anxiety/Nervousness</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty sleeping/insomnia</p> <p><input type="checkbox"/> Work/family stress</p> <p>BLOOD DISORDERS: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Bruising</p> <p><input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> Enlarged lymph nodes</p> <p>IMMUNOLOGIC: <input type="checkbox"/> <i>None</i></p> <p><input type="checkbox"/> Severe allergic reactions</p> <p><input type="checkbox"/> Frequent or severe infections</p> <p><input type="checkbox"/> Pollen allergies/hay fever</p>
--	--	---



Family Health History

Name: _____

Date of Birth: _____

Relative	Age	Currently Living (L) or Not Living (NL)*	*If NL, list cause of death	Has/Had Cancer or other Blood Disorders? If yes, list type: (i.e. breast, lung, colon, clotting issues, leukemia)
Mother				
Maternal Grandmother				
Maternal Grandfather				
Mother's Siblings				
Father				
Paternal Grandmother				
Paternal Grandfather				
Father's Siblings				
Your Child				
Your Child				
Your Child				
Your Sibling				
Your Sibling				
Your Sibling				
Your Sibling				
Your Nieces/Nephews				
Your Cousins				

Are you of Ashkenazi Jewish descent? Yes No

Are you concerned about your personal and/or family history of cancer? Yes No

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes No



Medication List

Patient Name: _____ Doctor: _____

Please include regularly taken over the counter drugs, herbs and vitamins.

Date	Drug / Prescription	Dose	Which MD prescribed medication	Date Medication Began

Allergies:

Are you allergic to shellfish and/or the dye used in x-rays? Yes No

Are you allergic to latex? Yes No

Please list all medications to which you are allergic and the kind of reaction (e.g. hives, breathing problems, rash):
