SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM

Patient Name: _____ _____
Last First M.I. Today's Date

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

☐ Yes ☐ No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____ Are you pregnant now ☐Y ☐N

Hysterectomy: ☐Y ☐N Ovaries removed ☐Y ☐N

Hormone use: ☐Y ☐N Oral contraceptive use ☐Y ☐N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Circle One: Male OR Female

Last mammogram: _____ Last Prostate exam: _____

Last Pap smear: _____ Last PSA screening: _____

Last colonoscopy: _____ Last Flu vaccine: _____

Last bone density scan: _____ _____

Last pneumonia vaccine: _____ _____

SOCIAL HISTORY

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐Y ☐N				
Tobacco:	☐Y ☐N				
Caffeine:	☐Y ☐N				
Recreational Drugs:	☐Y ☐N				

FAMILY HISTORY: Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			☐Y ☐N	Brothers:			☐Y ☐N
Father:			☐Y ☐N				☐Y ☐N
Grandmother (P):			☐Y ☐N				☐Y ☐N
Grandfather (P):			☐Y ☐N	Sisters:			☐Y ☐N
Grandmother (M):			☐Y ☐N				☐Y ☐N
Grandfather (M):			☐Y ☐N				☐Y ☐N
				Children:			☐Y ☐N
							☐Y ☐N
							☐Y ☐N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	☐Y	☐N
Poor Energy Level	☐Y	☐N
Fever	☐Y	☐N
Chills	☐Y	☐N
Night Sweats	☐Y	☐N

Eyes		
Double Vision	☐Y	☐N
Vision Loss	☐Y	☐N
Flashing Lights	☐Y	☐N

ENT/Mouth		
Ringing in Ears	☐Y	☐N
Hearing Loss	☐Y	☐N
Oral Ulcers	☐Y	☐N
Mouth Pain	☐Y	☐N
Sore Throat	☐Y	☐N
Difficulty Swallowing	☐Y	☐N
Hoarseness	☐Y	☐N

Cardiovascular		
Chest Pain	☐Y	☐N
Palpitations	☐Y	☐N
Fainting Spells	☐Y	☐N
Leg Swelling/Pain	☐Y	☐N
Arm Swelling/Pain	☐Y	☐N

Respiratory		
Cough	☐Y	☐N
Wheezing	☐Y	☐N
Shortness of Breath	☐Y	☐N
Coughing Blood	☐Y	☐N
Pain with Breathing	☐Y	☐N

Breast		
Mass	☐Y	☐N
Pain	☐Y	☐N
Nipple Discharge	☐Y	☐N
Change in Size	☐Y	☐N
Change in Shape	☐Y	☐N

Gastrointestinal		
Nausea	☐Y	☐N
Vomiting	☐Y	☐N
Jaundice	☐Y	☐N
Abdominal Pain	☐Y	☐N
Maroon/Black Stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Vomiting Blood	☐Y	☐N
Difficulty Swallowing	☐Y	☐N

Urinary		
Painful Urination	☐Y	☐N
Blood in Urine	☐Y	☐N
Increased Frequency	☐Y	☐N
Loss of Control	☐Y	☐N
Impotence	☐Y	☐N

Gynecological		
Vaginal Discharge	☐Y	☐N
Pelvic Pain	☐Y	☐N
Abnormal Bleeding	☐Y	☐N

Musculoskeletal		
Muscle Pain	☐Y	☐N
Spine Tenderness	☐Y	☐N
Swollen Joints	☐Y	☐N
Joint Redness	☐Y	☐N
Bone Pain	☐Y	☐N

Skin		
Rash	☐Y	☐N
Nodules	☐Y	☐N
Itchiness	☐Y	☐N
Lesions	☐Y	☐N

Neurological		
Confusion	☐Y	☐N
Seizures	☐Y	☐N
Fainting Spells	☐Y	☐N
Tremors	☐Y	☐N
Speech Change	☐Y	☐N
Headache	☐Y	☐N
Abnormal Gait	☐Y	☐N
Weakness	☐Y	☐N
Sensory Change	☐Y	☐N

Psychiatric		
Anxiety	☐Y	☐N
Depression	☐Y	☐N

Endocrine		
Excessive Urine	☐Y	☐N
Excessive Thirst	☐Y	☐N
Hot Flashes	☐Y	☐N
Heat/Cold Intolerance	☐Y	☐N

Hematological		
Nose Bleeds	☐Y	☐N
Bleeding Gums	☐Y	☐N
Easy Bruising	☐Y	☐N

Lymphatic		
Enlarged Lymph Nodes	☐Y	☐N
Swelling in Arms/Legs	☐Y	☐N

Radiation/Chemo History:

Previous Radiation Therapy: ☐ Yes ☐ No If yes, where?_____
Previous Chemotherapy: ☐ Yes ☐ No If yes, where?_____

Patient Preferences:

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? ☐ Yes ☐ No
Do you have a durable power of attorney or a living will? ☐ Yes ☐ No
Do you have a current Advanced Directive? ☐ Yes
☐ No
Are there any language barriers that the staff needs to be aware of? ☐ Yes ☐ No
Do you feel unsafe or threatened by anyone? ☐ Yes ☐ No
Do you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No

REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? _____

Have you ever accessed the VA for any services? Yes or No If so, what services did you use?
_____

Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.

_____
_____
_____
_____
_____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

ValleyHealth
Cancer Center

Current Medication Form

Name:_____
DOB: _____

Preferred Pharmacy: _____
Address: _____
Phone/ Fax: _____

Allergies & Adverse Reactions

Medication	Reaction

Current Medications

Prescriptions, over-the-counter, and herbal remedies

Medication	Dose	Schedule

Reviewed by: _____ **Date:** _____

WINCHESTER MEDICAL CENTER
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that any disclosure of information carries with it that potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

Patient Name (Last, First, MI):_____
Address:_____
Date of Birth:_____ Social Security #:_____
Medical Record Number:_____

Extent of nature of use/disclosure is limited to: (Check or list all that apply)
□ History & Physical
□ Discharge Summary
□ Medication List
□ Allergy List
□ Progress Notes
□ Consultation Reports
□ Physician Orders
□ Treatment Plan
□ Laboratory Results from (date)_____ to (date)_____
□ X-Ray and Imaging Reports from (date)_____ to (date)_____
□ Other:_____

I understand that the information in my health record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

To disclose information to:
Name, title and organization:_____
Address:_____
Phone/Fax:_____

Specified purpose or need for use/disclosure is:
□ Diagnosis/Treatment
□ Discharge Planning
□ Other:_____

Unless otherwise revoked, this authorization will expire in:
□ One Year
□ On (specify date or event):_____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the Health Information Management Director at 536-8081.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

RADIATION ONCOLOGY
400 CAMPUS BLVD., SUITE 110
WINCHESTER, VA 22601
Phone: 540-536-8912 Fax: 540-722-2635

I, _____, give permission to the following individuals to obtain information regarding my radiation therapy treatments, follow up care and billing for my radiation treatments through Winchester Medical Center.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Signature:_____

Date:_____

Witness:_____

Cancer Care Team of Referring Physicians

Surgical Oncology:

____ Dr. Flaherty
____ Dr. Hill
____ Dr. Villanueva
____ Dr. Reddy (Thoracic)
____ Dr. Elkas (Gynecologic)

Breast Surgeon:

____ Dr. Minghini
____ Dr. Mason

Medical Oncology:

____ Dr. Gemma
____ Dr. Houck III
____ Dr. Ingram
____ Dr. Jones
____ Dr. McCusker
____ Dr. O'Brien
____ Dr. Resta

Primary Care Provider or Any Additional Specialists:

_____

Preferred Pharmacy:

_____

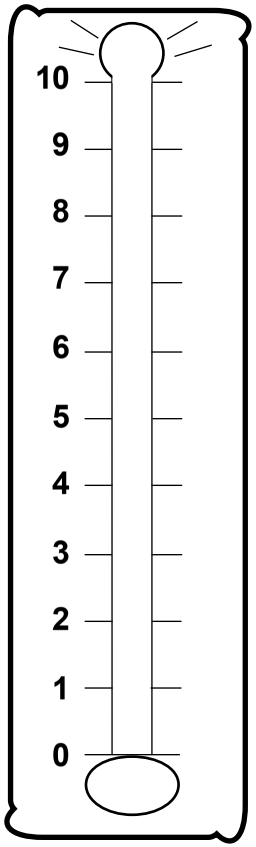
ValleyHealth
Cancer Center

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress



No distress

PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns

- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns

- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns

- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children

Practical Concerns

- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Work
- ❑ School
- ❑ Housing
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns

- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

_____

_____

_____

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Campus Site Plan

Winchester Medical Center is a tobacco-free campus. Thank you for your cooperation.

1. **Winchester Medical Center**
   1840 Amherst St
2. **Behavioral Health Center**
   1890 Amherst St
3. **Conference Center**
   1888 Amherst St
4. **Heart & Vascular Center**
   1880 Amherst St
5. **Medical Office Building I**
   1870 Amherst St
6. **Surgi-Center of Winchester**
   1860 Amherst St
7. **Wound Care Center**
   Valley Health Advanced MRI
   1830 Amherst St
8. **Medical Office Building II**
   190 Campus Blvd
9. **System Support**
   220 Campus Blvd
10. **Diagnostic Center**
    300 Campus Blvd
11. **Cancer Center**
    400 Campus Blvd, **Suite 110**
12. **Wellness & Fitness Center**
    401 Campus Blvd

8/17