BARBARA ANN Karmanos CANCER INSTITUTE

Patient Registration

Date: _____

Name: _____ **I prefer to be called:** _____
Last First MI

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home # (____) _____ **Cell #** (____) _____ **Work#** (____) _____

Which numbers may we use? ☐ Home ☐ Cell ☐ Work **May we leave a message?** ☐ Yes ☐ No

Email Address: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Retired ☐ Disabled Former or Current Occupation: _____

Have you served in the military ☐ No ☐ Yes Where: _____ When: _____

Spouse or Significant Other's Name: _____ **Phone:** (____) _____

If you are covered under your spouse's insurance, please provide their DOB: _____

Emergency Contact: _____ **Phone:** (____) _____ **Relationship:** _____

Race: ☐ Caucasian ☐ African American ☐ Decline to Answer ☐ American Indian ☐ Native Hawaiian ☐ Other _____ ☐ Asian ☐ Alaskan **Ethnicity:** ☐ Hispanic ☐ Non - Hispanic

Do you have a Legal Guardian? ☐ Yes ☐ No

If yes, please provide Guardians' Name: _____ Phone: (____) _____

Do you have an Advanced Directive? ☐ Yes ☐ No **If no, are you interested in information?** ☐ Yes ☐ No

Whom may we thank for referring you? _____

Doctor Information

Family/Primary Physician: _____ **Phone:** (____) _____

Referring Physician: _____ **Phone:** (____) _____

Additional Physicians: _____ **Phone:** (____) _____

Additional Physicians: _____ **Phone:** (____) _____

Name: _____

New Patient History

Briefly describe the reason for your visit:

_____

_____

_____

Cancer History

Type of your cancer: _____ Date of Diagnosis: _____

If you have had previous treatment, please include type of treatment below:

Treatment with surgery: ☐ Yes ☐ No When & Where: _____

Radiation Therapy: ☐ Yes ☐ No When & Where: _____

Chemotherapy: ☐ Yes ☐ No When & Where: _____

Medical History

Please check if you have had any of the following medical conditions

☐ Anemia	☐ Diabetes	☐ HIV/AIDS
☐ Anxiety	☐ Gallbladder Disease	☐ Kidney Disease
☐ Arthritis	☐ GERD or Acid Reflux	☐ Lupus/Scleroderma
☐ Asthma	☐ Glaucoma	☐ Pacemaker / Defibrillator
☐ Bleeding Disorders	☐ Heart Attack	☐ Seizures
☐ Blood Clots	☐ Heart Disease	☐ Stomach Ulcers
☐ Currently on Blood Thinners	☐ Hepatitis- ☐ A ☐ B ☐ C	☐ Stroke
☐ COPD/Emphysema	☐ High Blood Pressure	☐ Thyroid Disease
☐ Depression	☐ High Cholesterol	☐ Tuberculosis

Additional Comments: _____

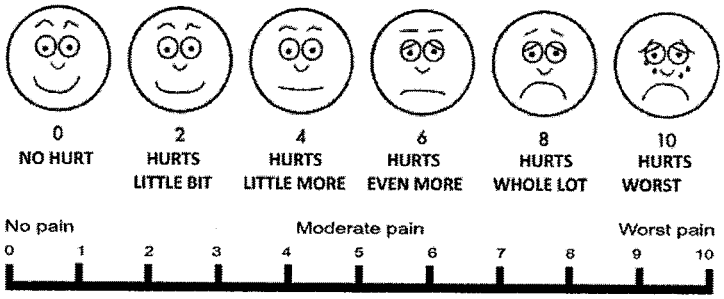
_____

Surgical History

Surgeries or hospitalizations	Date	Where
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

Name: _____

Pain



Where does it hurt? _____ Tell us what is your pain rating at its worst? _____

When did the pain start? _____

Is the pain: ☐ constant ☐ on-and-off ☐ dull ☐ sharp ☐ burning ☐ pressure

What relieves the pain? _____

How often do you have to take pain medication? _____ Pain rating after taking medication? _____

Genetic Risk Assessment

This is a screening tool for cancers that run in families. Please consider the following family members
Mother/Father/Sister/Brother/Children/Grandparent
Aunt/Uncle/Niece/Nephew/Cousin/Great-Grandparent

Have you or any of your relatives been tested for hereditary cancer in the past? ☐ YES ☐ NO

TYPE OF CANCER	YOUR RELATIONSHIP TO FAMILY MEMBER W/ CANCER			
	Self, sibling, child, parent	MOTHER'S SIDE	FATHER'S SIDE	AGE AT DIAGNOSIS
EXAMPLE: Colon	Sister			42

Name: _____

Current Medication List

List all medications you are taking, including vitamins, nonprescription drugs, and herbal supplements.

Drug	Amount/Dose	Frequency

Retail Pharmacy Name: _____ Phone# (_____) _____

Mail Order Pharmacy Name: _____ Phone# (_____) _____

Do you have prescription coverage? ☐ Yes ☐ No

Authorization to electronically submit prescription(s) directly to Pharmacy: _____
(Initials)

Allergy Information

Allergic To	Reaction

Immunizations

Vaccine Name: _____ Date Received: _____ From Whom: _____

Vaccine Name: _____ Date Received: _____ From Whom: _____

Name: _____

Social History

Religious Belief: ☐Catholic ☐Jewish ☐Protestant ☐Muslim ☐Other: _____
What is the highest level of education you have completed: ☐ 8th Grade or less ☐ Some high school, but did not graduate ☐ High school graduate or GED ☐ Some college or 2 -year degree ☐ 4 year college graduate ☐ More than 4 year college degree
Preferred Language: ☐English ☐ Spanish ☐ Arabic ☐ Other: _____
Translator: Would you like us to arrange a Translator for your visits? ☐ Yes ☐ No
Do you have someone living with you? Whom: _____ ☐ Yes ☐ No
Do you have reliable transportation for your medical appointments ☐ Yes ☐ No
Do you have family or friends available to help you during your treatments ☐ Yes ☐ No
Do you have emotional support from family members/friends ☐ Yes ☐ No
Would you like to speak to someone for emotional support ☐ Yes ☐ No
Are you currently being abused physically, sexually or emotionally ☐ Yes ☐ No
Safety Questions
Have you had a fall in the past six months ☐ Yes ☐ No
Do you need help with standing or walking ☐ Yes ☐ No
Do you use an assistive device ☐ Yes ☐ No
If so; please check: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair
Environmental Exposure
Asbestos ☐ Yes ☐ No
Toxic Chemicals ☐ Yes ☐ No
Other (list)
Tobacco & Other Substance Use
Smoking Status: ☐ Never ☐ Current ☐ Former
☐ Cigarettes ☐ Cigars/Pipe ☐ Chewing Tobacco ☐ Hookah ☐ Vape
Number of years you have smoked _____
How much do you smoke per day _____
When did you quit _____
Have you been exposed to secondhand smoke ☐ Yes ☐ No
Do you, or have you use marijuana ☐ Yes ☐ No
Have you used cocaine, heroin or other illegal substances ☐ Yes ☐ No
Alcohol Use
Alcohol Use: ☐ Never ☐ Social ☐ Daily ☐ Former
How many alcoholic beverages per day _____ or per week _____
Have you previously received treatment for alcohol or substance use ☐ Yes ☐ No

Name: _____

Recent Medical History

Please check all the boxes that apply to your health during the last **six months**:

General symptoms

Loss of appetite	☐ Yes	☐ No
Unexplained tiredness	☐ Yes	☐ No
Prolonged fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight loss/gain	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Wears Glasses/Contacts	☐ Yes	☐ No

Ears/Nose/Throat

Pain/Difficulty swallowing	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Do you wear hearing aids	☐ Yes	☐ No
☐ Right ☐ Left ☐ Both		
Dry Mouth	☐ Yes	☐ No
Persistent hoarse voice	☐ Yes	☐ No
Mass in the neck	☐ Yes	☐ No

Skin

Bruise easily	☐ Yes	☐ No
Persistent/recurring rash	☐ Yes	☐ No
Soft tissue mass	☐ Yes	☐ No

Cardiovascular

Irregular/rapid heartbeat	☐ Yes	☐ No
Chest pain or angina	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Ankle/leg swelling	☐ Yes	☐ No
Pacemaker/ICD	☐ Yes	☐ No
If yes, please bring your card		

Respiratory

Cough that persists	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Cough up blood	☐ Yes	☐ No
Painful Breathing	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Use supplemental oxygen	☐ Yes	☐ No
If yes, how many liters do you use? _____		

Gastrointestinal

Stomach pain or cramping	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Rectal bleeding	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Feeling of Fullness	☐ Yes	☐ No

Urinary

Burning/painful urination	☐ Yes	☐ No
Urinating frequently	☐ Yes	☐ No
Sensation of urgency	☐ Yes	☐ No
Trouble starting stream	☐ Yes	☐ No
Weak urinary stream	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Waking to urinate at night	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No
Painful or swollen joints	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Limited range of motion	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Loss of balance	☐ Yes	☐ No
Frequent headaches	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Numbness or tingling	☐ Yes	☐ No
Loss of strength	☐ Yes	☐ No
Seizures or tremors	☐ Yes	☐ No
Changes in speech	☐ Yes	☐ No

Psychological

Feeling anxious	☐ Yes	☐ No
Feeling depressed	☐ Yes	☐ No
Mood swings	☐ Yes	☐ No

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Female Gynecologic History

Breast History

Breast cyst, or lump	☐ Yes	☐ No	Right / Left / Both
Breast pain or tenderness	☐ Yes	☐ No	Right / Left / Both
Nipple discharge	☐ Yes	☐ No	Right / Left / Both
Previous breast biopsies	☐ Yes	☐ No	Right / Left / Both

Previous history of Breast Cancer: _____

Date of last mammogram: _____ Where performed? _____

Date of last Pap smear? _____ Where performed? _____

Menstrual History

Age when menstruation began? _____

Are you still having monthly periods? ☐ Yes ☐ No

Is your menstruation slight, moderate, heavy, or irregular? _____

Are you presently using an IUD or birth control pills? _____

Date of your last menstrual cycle: _____

Is there any possibility you could be pregnant at this time? ☐ Yes ☐ No

Please note that patients who have not had a tubal ligation, hysterectomy, or are post-menopausal may require additional lab work prior to starting any therapy.

Menopause

If you are no longer having a menstrual cycle, at what age did your monthly periods stop? _____

Did your menopause occur as a result of: ☐ Natural ☐ Surgery ☐ Following chemotherapy?

Do you experience hot flashes? ☐ Yes ☐ No

Any previous history of hormone use:

Contraceptive Hormone use: ☐ No ☐ If yes; for how many years: _____

Post Menopause Hormones: ☐ No ☐ If yes; for how many years: _____

Pregnancies

Number of pregnancies: _____

Number of children born alive: _____

What was your age at your first child was born? _____

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Wayne State University

Print Patient Name: _____

Authorized Patient Communication List

Patient or authorized person: I authorize any physician, hospital, or medical care facility to provide all information regarding my medical history and treatment to the Karmanos Cancer Institute. Photocopies of this form may be considered to be as valid as the original.

(Optional) Patient or authorized person: I authorize Karmanos Cancer Institute to discuss my medical condition and/or release medical information the following people (i.e. family members):

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

If our office is unable to reach you personally, may we leave protected health information such as test results, appointment dates or returned messages by the following forms of communication?

_____

Signature of Patient/ Authorized Individual **Date & Time**

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CANCER INSTITUTE
Wayne State University

Financial Statement

It is the patient's responsibility to know and understand the terms of their insurance policy: In/Out of network, deductibles, coinsurance, co-pays. Our staff will verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards. **CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.** For those patients with cancer who do not have an insurance plan, financial services and patient assistance programs may be available on a local, regional and national basis. These services include, but are not limited to, Medicaid and drug assistance programs sponsored by the major pharmaceutical company. Patients who know they are underinsured should contact our Patient Billing Department immediately for assistance on how to participate or enroll in these services.

- Facility charges will be submitted to your insurance carrier for consideration and may
  include a co-pay.
- Professional charges are billed separately. You will receive a statement following submission
  to your insurance carrier.

Pathologists, radiologists, laboratory and other specialists are required to submit separate invoices. If you have any questions regarding these invoices, please contact the providers at the telephone number printed on the statement.

I recognize and accept responsibility for services rendered and agree to the above financial statement.

Signature of patient or responsible party **Date & Time**

We care about you.

Tell us how you are feeling

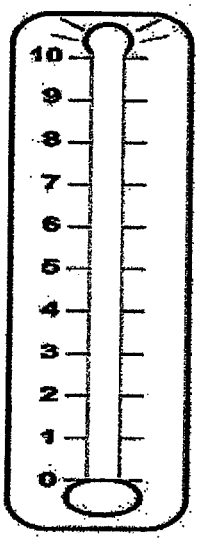
Name:_____

Date of Birth:_____

Today's Date:_____

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

Extreme distress



No distress

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
☐	☐	Treatment decisions

YES	NO	Family Problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues

YES	NO	Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	Feelings of abandonment
☐	☐	**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
☐	☐	Substance Abuse
☐	☐	Tingling in hands/feet

Other problems:_____

_____

_____

_____

_____

_____

_____

Reviewed by_____

Date _____ Time: _____

Referred to _____

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