RADIATION ONCOLOGY PATIENT MEDICAL HISTORY

Please print and complete to the best of your ability. DATE:

Patient Name	First	Last		Middle Initial		Home Phone	
Work Phone #		Cell Phone		E Mail Address			
Home Address				Employer & Address			
	Type of Dwelling:						
Date of Birth		Age		Marital Status	S M W D	Social Security Number	
Occupation		Education: High School yrs; College yrs					
Spouse/Other's Name:		Children's Names and ages					

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name & Address				Relationship to Patient	
Home Phone		Cell Phone		E Mail Address	
Employer & Address				Work Number	

PLEASE LIST OTHER TREATING PHYSICIANS

Name		Phone	
Name		Phone	
Name		Phone	
Name		Phone	
Name		Phone	
Dentist (only needed if you have a cancer of the head and neck region):			

Last influenza (flu) shot approximate date (month/year):

COVID shot approximate dates (month/year):

Would you like a chaperone for examinations? Yes No

MEDICATION INFORMATION

Pharmacy		Phone	
Address			

List all medications you are taking at this time: (Please include dosage and how you take it)

1		5	
2		6	
3		7	
4		8	

Allergies to Medication: (list names of drugs which you are allergic to)		
Environmental Allergies:		

Do you have a Living Will/Advanced Care Plan or have a Surrogate Decision Maker?
Yes_____ No _____ (If yes, please provide us with a copy for your record)

Would you like information about them? Yes_____ No_____

OVER
TO CONTINUE →

MEDICAL HISTORY:	Do you have or have you had: (please check appropriate boxes)							
	YES	NO		YES	NO		YES	NO
Diabetes			Stomach Problems			Lupus/Scleroderma		
High Blood Pressure			Colitis/Crohn's			Tuberculosis		
Heart Problem			Kidney Disease			Arthritis		
Stroke			Lung Problem			History of Seizures		

Cancer other than present diagnosis (what type if the answer is yes):

Have you FALLEN in the last year? Yes or No

Are you receiving VNA services? Yes or No | **Designated Care Giver:**

Other problems not listed above:

Do you have a pacemaker/defibrillator? Yes or No (if yes, add Manufacturer)

Do you have an implanted port or pump? Yes or No (if yes, add type)

Chemotherapy therapy now or in the past?	Yes	No	Hormonal therapy now or in the past?	Yes	No
Have you had radiation therapy in the past?	Yes	No			

Surgeries/Procedures	Date (mo/year)	Hospital

Family History: (parents' health history and any family cancer history)

Father:

Mother:

Other family members with cancer/type of cancer:

Social History

Do you drink alcohol? **Yes** **No** Amount/Type:

Do/did you use tobacco/vape/marijuana? **Yes** **No** How many years? Packs per day?

When did you quit if you used tobacco products in the past?

Do you use illegal drugs or prescription drugs without a prescription?

Review of Systems: Circle all that are positive responses/and Fill in responses as appropriate

General	Appetite change	Weight loss/#lbs:		Weight gain	Fevers	Chills	Night Sweats	Excessive Tiredness
Skin	Rash	Itching	Jaundice		Drains		Ostomy	
Head/Eyes	Vision change	Headaches	Dizziness	Eye pain				
Ear/Nose	Hearing change	Ringing in ear	Nose bleeds	Ear pain				
Mouth/Throat	Lumps in neck	Mouth pain	Throat pain	Problem swallowing	Taste change	Hoarse voice	Wear Dentures	
Respiratory	Short of breath	Persistent cough	Cough up blood	Wheezing				
CV	Chest pains	Ankle swelling	Fainting	Irregular heart rate				
GI	# bowel movements per day: ___	Crohn's Disease	Ulcerative colitis	Diarrhea	Heartburn	Bloody stools	Constipation	
GU	# times urinating at night:	Weak stream	Freq. Urination	Painful urination	Leakage of urine	Blood in urine	Penile discharge	
Endo	Breast mass	Nipple Disch.	Hot flashes					
Musculoskel	Joint pains	Joint stiffness	Muscle weakness	Muscle pain	Bone pain			
Neuro	Tingling	Numbness	Loss of balance	Speech problems	Blacking out	Problems remembering		
Psych	Excessively anxious		Depressed	Personality change				
Heme/Lymph	Anemia	Bruise easily	Swollen glands					
Sexual - Men	Change in sexual function		Problems with penile erection (are you taking medication for this?)					
Women	Change in sexual function		Pain/bleeding on intercourse	Vaginal bleeding				
	If ever been pregnant, how many times _____ ; Age at first pregnancy _____			Age of first menstrual period _____				
	If completed menopause, at what age _____	Ever nursed?	Used hormone replacement therapy? _____					

Pain (0 is no pain; 1-3 mild pain; 4-7 moderate to severe pain; 8-10 very severe pain):

Patient Name:

Physician Signature/Date

Kal: 5/13/21

Community CancerCare
Radiation Oncology

NRRON LLC
100 Haynes Street, Manchester, CT 06040
142 Hazard Ave, Enfield, CT 06082

General Consent for Treatment

I hereby give my consent to NRRON LLC to administer any treatment and/or testing deemed necessary by my physician or designee. I understand that such testing is voluntary and I can choose not to be tested. I authorize NRRON LLC to take photographs and/or video for medical records, medical education and physician records used in connection with my care and treatment.

Assignment of Benefits

I hereby authorize my insurance company to pay directly to NRRON LLC all insurance benefits otherwise payable to me but not to exceed regular charges for outpatient treatment. I understand that I will be responsible for charges not covered by my health insurance plan, which may include but are not limited to all copayments, deductibles and non-covered services. I further agree that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed to NRRON LLC by myself.

Personal Valuables

I understand that NRRON LLC is not responsible for valuables or clothing that is kept with me while receiving services in the facility.

Authorization to Release Information

I authorize NRRON LLC to release to my insurer(s) or their agent(s) any and all medical information as may be necessary for payment of my visit and medical claim. This release also allows information to be disclosed for third party utilization reviews/financial audits, workers compensation and automobile insurance claims. I authorize NRRON LLC to release information for my continuing care to my primary care physician and other healthcare providers, who are independent contractors who are not employed by, nor are agents of NRRON LLC. I recognize and consent to the supervised involvement of students, if applicable. I understand that this authorization may be revoked at any time except to the extent that action has already been taken in reliance upon it. I agree that NRRON LLC may contact me by telephone at any telephone number associated with this account for notification and collection purposes. Methods of contact may include manually dialed calls, using pre-recorded voice messages and use of automated dialing systems, as applicable.

Service Provided by Independent Contractors

I acknowledge and understand that the Radiation Oncologist professional services that I may receive at NRRON LLC will be provided by physicians who are self-employed, independent contractors, and I will receive a bill directly from them for their services. I understand that I will be responsible for charges not covered by my health insurance plan, which may include but are not limited to all copayments, deductibles and non-covered services.

By my signature below I certify that I have read the above, understand its contents and *agree to the items notated*. I also acknowledge receipt of NRRON LLC's Notice of Privacy Practices currently in effect.

Print name_____ Signature_____ Relationship_____

Witnessed By_____ Date_____

Additional authorized parties to speak on behalf of patient

Name	Relationship to Patient	Phone #
_____	_____	_____
_____	_____	_____

Can messages be left on your phone? ☐ Yes ☐ No

For Facility Use:

☐ Patient and family unable to sign ☐ Patient refused to sign ☐ Emergency treatment situation