Patient Name _____

Date of Birth _____

Thank you for choosing Southern Cancer Center for your care. To help us best prepare for your appointment, please complete this form and bring it to your appointment. If you have questions, please call us at 251-625-6896.

Health Questionnaire

PHYSICIAN AND PHARMACY INFORMATION

Physician who **referred** you to this visit_____ **or** □ Self referred

Primary Care Physician:

_____ _____
Name Specialty

_____ (_____)_____
City State Telephone

Specialty physician (Surgeon, Ob/Gyn, Oncologist, Cardiologist, other):

_____ _____
Name Specialty

_____ _____
Name Specialty

Pharmacy: For most of our pharmacy needs, we use:

_____
Name of Pharmacy

_____ (_____)_____
Address Telephone

_____
City State Zip

Patient Name _____

Date of Birth _____

MEDICAL HISTORY

Please list: 1) Current medical problems, prior medical illnesses/hospitalizations
2) Prior surgeries, procedures, recent scans/test

Date	Description	Physician/Medical Facility

Have you ever been diagnosed with cancer? If yes did you receive chemotherapy? □ Yes □ No

Describe the situation: _____

Have you ever received radiation? □ Yes □ No

Describe the situation: _____

Have **you** had any of the following illnesses? If so, please mark with an X:

□ High blood pressure
□ Diabetes
□ Heart attack
□ Congestive heart failure
□ Heart murmur
□ Stroke
□ Liver disease
□ Hepatitis
□ Kidney disease
□ Thyroid disease
□ Autoimmune/connective tissue disease (lupus, scleroderma etc.)
□ HIV/AIDS
□ Asthma/COPD
□ Tuberculosis
□ Sleep apnea
□ Reflux/GERD
□ Depression
□ Anxiety
□ Arthritis
□ Easy bleeding
□ Blood clots
□ Anemia
□ Atrial Fibrillation
□ Pacemaker
□ Other_____
□ _____
□ _____
□ _____
□ _____

Patient Name _____

Date of Birth _____

Medications

Please list all medications you are currently taking, including those you buy without a doctor's prescription.

Name	Dose	Directions/Number per day

Do you currently take oral iron supplements? Yes or No

Allergies and Sensitivities

Are you allergic to or have you had a bad reaction to any medicine or other substance? If, so please describe. *If you have a history of penicillin allergy, please note date of onset, reaction, and whether you have been able to take Keflex, Amoxicillin, Augmentin afterwards.*

Allergic to:	Reaction:

Patient Name _____

Date of Birth _____

Health Maintenance: Please list the date of last exam and, if abnormal, any findings if known.

- Last mammogram: ____/____/____ Location: _____
- Last colonoscopy: ____/____/____ Location: _____
- Last bone density scan: ____/____/____ Location: _____
- Last Echocardiogram: ____/____/____ Location: _____
- Shingles vaccine: ____/____/____
- Influenza vaccine ____/____/____
- Pneumovax vaccine ____/____/____
- COVID-19 vaccine ____/____/____ Circle One: Janssen Pfizer Moderna

FAMILY HISTORY

Please check below if any blood relative has had any of the following conditions and note **which relatives** (**and whether on maternal/paternal side**) are affected.

□ Diabetes
□ Heart attack
□ Stroke
□ Kidney disease
□ Thyroid disease
□ Autoimmune disease
□ Easy bleeding
□ Blood clots

Cancer Which type:_____ Relationship to you:_____ Age diagnosed:_____

Cancer Which type:_____ Relationship to you:_____ Age diagnosed:_____

Is there a history of the following cancers (circle):

Breast / Ovarian / Uterine / Colon / Prostate / Pancreatic / Melanoma

Patient Name _____

Date of Birth _____

PERSONAL HISTORY

Currently live: □ Alone □ With family □ With significant other □ With friends

Marital status: □ Married □ Separated □Divorced □ Widowed □ Never married

Occupation:_____

Do you have children? □ Yes □ No Ages: _____

Do you currently smoke or chew tobacco? □ Yes □ No Cigarettes per day:_____ Packs per week: _____

Duration of habit (yrs.): _____ If you have a history of smoking, when did you quit? _____

How would you describe your use of alcohol?_____

Amount per week of: Beer_____ Wine_____ Liquor_____

Do you now, or have you in the past, used drugs? □ Yes □ No Type: _____

Do you have an Advanced Directive (Living Will, Durable Power of Attorney)? □ Yes □ No

REVIEW OF SYSTEMS

Please circle any of the following which apply to you.

Category	Issues	No Problems
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	□
Skin	Itching, rash, mole change	□
Eyes	Vision change, cataracts, glaucoma	□
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	□
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	□
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	□
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	□
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	□
Breasts	Discharge, mass, pain, tenderness	□
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	□
Nervous System	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling	□
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	□
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	□
Lymph nodes	Enlargement, tenderness	□
Hematologic	Bruising, bleeding, recurrent infections	□

Patient Name _____

Date of Birth _____

Gynecologic History (Female Only)

- At what age did you start menstruating? _____years old
- Last menstrual period: ____/____/____
- Are you pregnant? □ Yes □ No
- *Total* number of pregnancies_____ Miscarriages/terminations_____ Number living children_____
- Age at first pregnancy _____years old
- Do you wish to maintain future fertility? □ Yes □ No □ Not applicable
- Are you sexually active? □ Yes □ No
- Onset of menopause: _____year/age
- Last Pap smear: ____/____/____
- Any abnormal Pap smears? □ Yes □ No Description: _____
- Any history of pelvic infections (Gonorrhea, Chlamydia, herpes)? Description: _____
- Did you ever breast feed? □ Yes □ No If yes, for how long?_____
- Have you ever taken oral contraceptive pills? □ Yes □ No If yes, for how long?_____
- Have you ever taken hormone replacement therapy? □ Yes □ No If yes, for how long?_____
- Are you currently on a bisphosphonate (Aredia, Fosamax, Boniva, Reclast, Prolia, Actonel, Olpadronate, Nerixia)?

Behavioral Expectations for Treatment at Southern Cancer Center

Our goal is to provide the best possible care to everyone who comes into Southern Cancer Center. To provide the best coordinated care we wish to make the following expectations clear:

Southern Cancer Center employees will:

1. Act as a team and to behave in a professional manner.
2. Respect your goals for treatment and care.
3. Treat every patient with equality and respect.
4. Facilitate your care by scheduling appointments as close to requested times as possible.

Southern Cancer Center expects patients and their caregivers to:

1. Be respectful of the staff, other patients and their caregivers in all areas of the clinic.
2. Do not utilize derogatory statements, profanity, or threats with staff, patients or their caregivers.
3. Do not raise your voice when talking with staff, patients or their caregivers.
4. Do not make demands on staff members that disregard Southern Cancer Center rules and guidelines.
5. Keep your scheduled appointment time. If you are unable to make your appointment, please notify the clinic 24 hours in advance.

We realize that coping with the effects of cancer and treatment can be challenging at times. If you are having difficulty coping, please contact the social worker, Stephanie Andrews.

If you have concerns about interactions with staff, we welcome you to share those concerns with Regena Price RN/BSN/OCN, Director of Clinical Services.

I have read and understand the above-listed behavioral expectations. I understand that failure to meet these expectations may result in immediate termination of the relationship between me and this provider/organization.

Patient signature: _____ Date: _____

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name:_____ID_____

I hereby agree that Coastal Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Coastal Pharmacy for pharmaceuticals that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to Coastal Pharmacy, any and all information which will assist in processing my claims for pharmaceuticals that I am receiving from Coastal Pharmacy even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or Coastal Pharmacy any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals that I have received, rather than directly to Coastal Pharmacy, I agree to endorse those checks and send them immediately to Coastal Pharmacy

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Coastal Pharmacy financial hardship program.

I understand that prescribed pharmaceuticals cannot be re-dispensed. Therefore, these items cannot be returned for credit. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

_____**(Initials) I acknowledge that in the event I am unable to afford my prescription copays, the staff of Coastal Pharmacy have my permission to act on my behalf solely as agents to help me find and apply for appropriate financial assistance. I authorize Coastal Pharmacy to use my information to complete phone, electronic, or hardcopy applications and to sign those applications on my behalf to determine my eligibility.**

I have reviewed and understand the information above. Once my treatment plan has been decided by my SCC provider, I will be given the option of filling with Coastal Pharmacy. A pharmacist will contact me to be sure I have been instructed on and understand the use of the products provided. I will receive a copy of a patient handout that contains, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug information. I will also receive monograph/instructions for medications received. I will receive pharmacy marketing material and information on the pharmacy's scope of services which will also contain instructions on how to follow up with Coastal Pharmacy

Identified needs/problems: The patient may be unfamiliar with use of the pharmaceuticals provided. Expected outcomes: The patient will be provided the pharmaceuticals to comply with the physician's prescription. The patient will use the pharmaceuticals as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X_____DATE:____/____/____

PATIENT/RESPONSIBLE PARTY PRINT NAME: _____

WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

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