



Patients Name: _____

Account Number _____

REQUEST TO RELEASE HEALTH INFORMATION ACCESS

1. I hereby allow Florida Gynecologic Oncology to communicate to the following family members or friends

<u>NAME</u>	<u>RELATIONSHIP</u>

Patient Signature

Date of Birth

Signature of Legal Representative

Pt. Relationship

Witness Signature

Today's Date

FLORIDA GYNECOLOGIC ONCOLOGY

James W. Orr, M.D. Edward C. Grendys, M.D. Fadi Abu Shahin, M.D.
 Robert E. Barden, M.D. Denyse M. Mahoney, PA-C Helen M. Robbins, PA-C

Name: _____

Date: _____

Please place a check mark on the lines below for yourself and for each family member who has colon, endometrial, breast or ovarian cancer. Age refers to you or your family's age when cancer was diagnosed.

	<u>Colon Cancer</u>	<u>Colon Cancer</u>	<u>Endometrial Cancer</u>	<u>Endometrial Cancer</u>	<u>Breast Cancer</u>	<u>Ovary Cancer</u>
	<u>Before 50</u>	<u>After 50</u>	<u>Before 50</u>	<u>After 50</u>	<u>Before 50</u>	<u>Any age</u>
<u>YOURSELF</u>	_____	_____	_____	_____	_____	_____
<u>Mother</u>	_____	_____	_____	_____	_____	_____
<u>Father</u>	_____	_____	_____	_____	_____	_____
<u>Sister(s)</u>	_____	_____	_____	_____	_____	_____
<u>Brother(s)</u>	_____	_____	_____	_____	_____	_____
<u>Daughter(s)</u>	_____	_____	_____	_____	_____	_____
<u>Son(s)</u>	_____	_____	_____	_____	_____	_____
 <u>MOIHERS SIDE</u>						
<u>Grandmother</u>	_____	_____	_____	_____	_____	_____
<u>Grandfather</u>	_____	_____	_____	_____	_____	_____
<u>Aunt(s)</u>	_____	_____	_____	_____	_____	_____
<u>Uncle(s)</u>	_____	_____	_____	_____	_____	_____
<u>Cousin(s)</u>	_____	_____	_____	_____	_____	_____
 <u>FATHERS SIDE</u>						
<u>Grandmother</u>	_____	_____	_____	_____	_____	_____
<u>Grandfather</u>	_____	_____	_____	_____	_____	_____
<u>Aunt(s)</u>	_____	_____	_____	_____	_____	_____
<u>Uncle(s)</u>	_____	_____	_____	_____	_____	_____
<u>Cousin(s)</u>	_____	_____	_____	_____	_____	_____

Are you of Ashkenazi Jewish Descent? Yes _____ No _____
 Do you have male relatives with breast cancer? Yes _____ No _____

Consider further evaluation for hereditary cancer syndrome if:

- Colon or endometrial cancer diagnosed before age 50
- Two first degree relatives with colon or endometrial cancer at any age
- Two or more tumors in the same individual (colon and/or endometrial cancer)
- Two or more relatives with breast cancer before age 50
- Ashkenazi Jewish descent and any cases of breast cancer before age 50 or ovarian cancer at any age
- Any male relative with breast cancer



FLORIDA GYNECOLOGIC ONCOLOGY

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H. Michele Robbins, P.A.-C

NEW PATIENT CONSULTATION

Name: _____ Age: _____ Date: _____

Patient E-mail Address: _____

Names of your other doctors: _____

Why did you come to see the doctor today? _____

Do **you** have, or have you ever had, any of the following medical problems (please check all that apply to you)?

Diabetes

Heart Disease

Kidney Disease

Liver Disease

Tuberculosis

Thyroid Dysfunction

Epilepsy / Seizures

Phlebitis

Allergies

Hypertension

Blood Clots

Cancer

Breast Disease

Lung Disease

Bleeding Problems

Other: _____

Have you ever been hospitalized? Yes No

If yes, when, where and what for? _____

Have you ever had surgery? Yes No

If yes, what for, when and where? _____

List **all** current medications: _____

Are you allergic to any medications? Yes No

Please list and explain reaction: _____

Are you having menstrual periods? Yes No

If yes, date of last period: _____ Are your menstrual periods: Regular Moderate Heavy Irregular

If you are not having menstrual periods, when did they stop? Date: _____ Age: _____

Have you been sexually active in the past? Yes No

Are you currently sexually active? Yes No

How many times have you been pregnant? _____ How many children do you have? _____

If you are sexually active, what form of birth control are you using?

Nothing

Withdrawal

Condoms

Sponge

Foam

Diaphragm

IUD

Rhythm Method

Birth Control Pills

Tubal Ligation

Partner Vasectomy

Does your **family** have a history of (please check all that apply to your family):

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Breast Disease |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Other: _____ |

Do you use: Tobacco (how much): _____ Alcohol: _____ Narcotics: _____

Have you been tested for HIV? Yes No

If yes, date and result: _____

REVIEW OF SYSTEMS (please check all that apply to you)

- | | | | | |
|-------------------------|---------------------------------|---|--|---|
| Skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Rash | <input type="checkbox"/> Ulcers | |
| Neurological | <input type="checkbox"/> Normal | <input type="checkbox"/> Seizures | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Syncope/Pass Out |
| Psychiatric | <input type="checkbox"/> Normal | <input type="checkbox"/> Depression | | |
| Endocrine | <input type="checkbox"/> Normal | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hot Flashes |
| Urinary | <input type="checkbox"/> Normal | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Pain on Urination | |
| | | <input type="checkbox"/> Leakage of Urine | <input type="checkbox"/> Urgency to Void | |
| Genital | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Breast Pain |
| Sex Function | <input type="checkbox"/> Normal | <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Bleeding after Intercourse | <input type="checkbox"/> Lack of Desire |
| Hematology | <input type="checkbox"/> Normal | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Spontaneous Bleeding | |
| | | <input type="checkbox"/> Enlarged Lymph Nodes | | |
| Allergy | <input type="checkbox"/> Normal | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Drug Allergies | |
| General | <input type="checkbox"/> Normal | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue | |
| Eyes | <input type="checkbox"/> Normal | <input type="checkbox"/> Change in Vision | | |
| Ears/Mouth | <input type="checkbox"/> Normal | <input type="checkbox"/> Problems Hearing | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Normal | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath with Exercise | |
| | | <input type="checkbox"/> Shortness of Breath in Bed | | |
| Respiratory | <input type="checkbox"/> Normal | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | |
| | | <input type="checkbox"/> Respiratory Infection (cold) | | |
| Gastrointestinal | <input type="checkbox"/> Normal | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood Stools |
| Musculoskeletal | <input type="checkbox"/> Normal | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Arthritis | |

HealthCare Screening Tests: (please list date and result of most recent test)

Pap Test: _____ Mammogram: _____ Colorectal Screen: _____

Signature: _____ Date: _____



**FLORIDA
GYNECOLOGIC
ONCOLOGY**

(PLEASE PRINT)

PATIENT REGISTRATION

Name: _____ Date: _____

Date of Birth: _____ Social Sec. #: _____ Marital Status: S M W D

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Permanent Phone Number: () _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Local Phone Number: () _____

Name of Employer: _____

Work Phone: () _____

If student, name of school: _____

IF MARRIED OR A MINOR, PLEASE COMPLETE

Name of Spouse or Parent: _____

Social Security #: _____

Address (if different): _____

Employer: _____ Phone: _____

If Patient is a minor, list below those who may authorize treatment of child:

In Case of Emergency, Please Notify:

Name: _____ Phone: _____

Do you have health insurance? Yes No Type: HMO PPO Other: _____

If no, what will be your form of payment? _____

Insurance Company Name: _____ Is your spouse on this insurance plan? Yes No

Address: _____ City: _____ Zip Code: _____

Telephone: () _____ Name of Policy Holder: _____

Policy Number: _____ Group Number: _____/ID# _____

Referred By: _____ Telephone: () _____

Pharmacy Name: _____ Telephone: () _____

Authorized to Treat

The undersigned patient and/or responsible person or relative hereby consent(s) to authorize Florida Gynecologic Oncology, affiliated physicians and allied health personnel, to administer and perform any and all medical examination(s) and treatment(s) diagnosed and surgical procedures which may now, or during the course of the patient's care, be deemed advisable and/or necessary.

Authorization of Payment and Release of Records

I hereby authorize assignment of payments to Florida Gynecologic Oncology. I authorize the release of all records to process insurance claims, or to any physician I may be referred to.

Signature of Patient: _____ Date/Time: _____

Signature of Witness: _____ Date/Time: _____