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: _____

Signature of Witness: _____ Date: _____

FLORIDA GYNECOLOGIC ONCOLOGY

James W. Orr, Jr., M D
FACOG, FACS
Medical Director
Florida Gynecologic Oncology and Regional Cancer Center

Edward C. Grendys Jr., M D
FACOG, FACS
Director Clinical Research

Fadi Abu Shahin, M D
Robert E Barden, M D FACOG
Denyse M Mahoney, P.A.-C
Megan Tetlow, P.A.-C

NEW PATIENT CONSULTATION

Name: _____ Age: _____ Date: _____

Patient E-mail Address: _____

Names of your doctor(s): _____

Why did you come to see the doctor today? _____

_____

Pharmacy Name: _____ Phone Number: _____

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

❑ Diabetes	❑ Tuberculosis	❑ Allergies	❑ Breast Disease
❑ Heart Disease	❑ Thyroid Dysfunction	❑ Hypertension	❑ Lung Disease
❑ Kidney Disease	❑ Epilepsy / Seizures	❑ Blood Clots	❑ Bleeding Problems
❑ Liver Disease	❑ Phlebitis	❑ Cancer	❑ Other: _____

In case of radical/surgical emergency, do you accept blood transfusion? ❑ Yes ❑ No

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? Year: _____

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? _____

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

- ❑ 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: _____

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

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

Pap Test: _____ Mammogram: _____ Colonoscopy: _____

Signature: _____ Date: _____

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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.

	Colon Cancer Before 50	Colon Cancer After 50	Endometrial Cancer Before 50	Endometrial Cancer After 50	Breast Cancer Before 50	Ovary Cancer Any age
YOURSELF						
Mother						
Father						
Sister(s)						
Brother(s)						
Daughter(s)						
Son(s)						
MOTHERS SIDE						
Grandmother						
Grandfather						
Aunt(s)						
Uncle(s)						
Cousin(s)						
FATHERS SIDE						
Grandmother						
Grandfather						
Aunt(s)						
Uncle(s)						
Cousin(s)						

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

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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.

NAME	RELATIONSHIP

_____ _____

Patient Signature Date of Birth

_____ _____

Signature of Legal Representative Pt Relationship

_____ _____

Witness Signature Today's Date