Cancer & Blood
SPECIALISTS OF ARIZONA
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship to Patient

_____ _____

Signature of Witness Date

_____

Printed Name of Witness

Place Label Here

Patient Name: _____ **DOB:**_____

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age**: _____ ❑ **Male** ❑ **Female** **SS#**: _____

Primary Address: _____

City: _____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race (check all that apply): ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets:_____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____ Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will ❑ Yes ❑ No **Durable Power of Attorney** ❑ Yes ❑ No **DNR** ❑ Yes ❑ No

If yes, please bring a copy with you.

Patient Name: _____ **DOB:** _____

Medical History Have you EVER had any of the following:

- ❑ Asthma
- ❑ Psychiatric Disorder/Illness
- ❑ Cancer
- ❑ Seizures or Epilepsy
- ❑ Diabetes
- ❑ Urinary/Kidney Disorder
- ❑ Neurological Disorder/Chronic Headaches
- ❑ Blood Pressure Disorder/Hypertension
- ❑ Stroke
- ❑ COPD
- ❑ Thyroid Disorder
- ❑ Heart Attack/Heart Disease/Atrial Fib
- ❑ Arthritis
- ❑ Pulmonary Embolism/DVT/Blood Clots
- ❑ Cholesterol Disorder/Hyperlipidemia
- ❑ Sleep Apnea
- ❑ Eye Disorder (i.e. Glaucoma)
- ❑ Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? ❑ Yes ❑ No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Allergies

Are you allergic to any medications or other substances? ❑ Yes ❑ No Please list allergies and reactions:

_____

_____

Patient Name: _____ **DOB:** _____

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? ❑ Yes ❑ No If yes, please use the back of this page to list all others.

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? ❑ Yes ❑ No

Date of last mammogram: _____ Was that mammogram normal? ❑ Yes ❑ No

Date of last colonoscopy: _____ Was that colonoscopy normal? ❑ Yes ❑ No

Family Medical History Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Social History

Do you currently smoke? ❑ Yes ❑ No If no, previously? ❑ Yes ❑ No

Years smoked_____ Packs per day_____ Year quit_____

Do you use other tobacco products? ❑ Yes ❑ No Consume Alcohol? ❑ Yes ❑ No If yes, drinks per week_____

Do you do any drugs (including marijuana)? ❑ Yes ❑ No If yes, what drug and for how long?_____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Do you suffer from domestic violence? ❑ Yes ❑ No Do you feel safe at home? ❑ Yes ❑ No

Patient Name: _____ **DOB:** _____

Review of Systems Please indicate ALL that you have experienced within the last three months.

General

❑ None ❑ Feeling Tired ❑ Fever ❑ Weight Gain
❑ Chills ❑ Weight Loss ❑ Feeling Poorly

Eyes

❑ None ❑ Dry Eyes ❑ Eye Pain ❑ Itchy Eyes
❑ Vision Changes ❑ Eyesight Problems

Ear/Nose/Throat

❑ None ❑ Earache ❑ Loss of Hearing ❑ Nose Bleeds
❑ Sinus Problems ❑ Sore Throat ❑ Hoarseness

Heart

❑ None ❑ Chest Pain ❑ Palpitations ❑ Slow Heart Rate
❑ Leg Swelling ❑ Fast heart rate ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

❑ None ❑ Cough ❑ Wheezing ❑ Shortness of Breath
❑ Trouble breathing with exertion ❑ Trouble breathing when lying flat

Gastrointestinal

❑ None ❑ Abdominal Pain ❑ Constipation ❑ Diarrhea
❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Blood in stool

Skin

❑ None ❑ Acne ❑ Itching ❑ Change in mole
❑ Skin Lesions ❑ Skin Wound ❑ Breast Lump

Neurological

❑ None ❑ Limb Weakness ❑ Confused ❑ Loss of Memory
❑ Convulsions ❑ Headaches ❑ Dizziness ❑ Difficulty Walking

Psychiatric

❑ None ❑ Suicidal ❑ Anxiety ❑ Disturbed Sleep
❑ Depression ❑ Emotional Problems ❑ Change in Personality

Endocrine

❑ None ❑ Hair Loss ❑ Weak Muscles ❑ Hot Flashes
❑ Feeling Weak ❑ Deepening Voice

Hem/Lymph

❑ None ❑ Easy Bleeding ❑ Easy Bruising ❑ Swollen Glands

Patient Name: _____ **DOB:**_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ **I give permission to the employees of Cancer & Blood Specialists of Arizona (CBSA), a division of American Oncology Partners (AOP), to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)