SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM

Patient Name: _____ _____
Last First M.I. Today's Date

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

☐ Yes ☐ No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____ Are you pregnant now ☐Y ☐N

Hysterectomy: ☐Y ☐N Ovaries removed ☐Y ☐N

Hormone use: ☐Y ☐N Oral contraceptive use ☐Y ☐N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Circle One: Male OR Female

Last mammogram: _____ Last Prostate exam: _____

Last Pap smear: _____ Last PSA screening: _____

Last colonoscopy: _____ Last Flu vaccine: _____

Last bone density scan: _____ _____

Last pneumonia vaccine: _____ _____

SOCIAL HISTORY

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐Y ☐N				
Tobacco:	☐Y ☐N				
Caffeine:	☐Y ☐N				
Recreational Drugs:	☐Y ☐N				

FAMILY HISTORY: Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			☐Y ☐N	Brothers:			☐Y ☐N
Father:			☐Y ☐N				☐Y ☐N
Grandmother (P):			☐Y ☐N				☐Y ☐N
Grandfather (P):			☐Y ☐N	Sisters:			☐Y ☐N
Grandmother (M):			☐Y ☐N				☐Y ☐N
Grandfather (M):			☐Y ☐N				☐Y ☐N
				Children:			☐Y ☐N
							☐Y ☐N
							☐Y ☐N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	☐Y	☐N
Poor Energy Level	☐Y	☐N
Fever	☐Y	☐N
Chills	☐Y	☐N
Night Sweats	☐Y	☐N

Eyes		
Double Vision	☐Y	☐N
Vision Loss	☐Y	☐N
Flashing Lights	☐Y	☐N

ENT/Mouth		
Ringing in Ears	☐Y	☐N
Hearing Loss	☐Y	☐N
Oral Ulcers	☐Y	☐N
Mouth Pain	☐Y	☐N
Sore Throat	☐Y	☐N
Difficulty Swallowing	☐Y	☐N
Hoarseness	☐Y	☐N

Cardiovascular		
Chest Pain	☐Y	☐N
Palpitations	☐Y	☐N
Fainting Spells	☐Y	☐N
Leg Swelling/Pain	☐Y	☐N
Arm Swelling/Pain	☐Y	☐N

Respiratory		
Cough	☐Y	☐N
Wheezing	☐Y	☐N
Shortness of Breath	☐Y	☐N
Coughing Blood	☐Y	☐N
Pain with Breathing	☐Y	☐N

Breast		
Mass	☐Y	☐N
Pain	☐Y	☐N
Nipple Discharge	☐Y	☐N
Change in Size	☐Y	☐N
Change in Shape	☐Y	☐N

Gastrointestinal		
Nausea	☐Y	☐N
Vomiting	☐Y	☐N
Jaundice	☐Y	☐N
Abdominal Pain	☐Y	☐N
Maroon/Black Stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Vomiting Blood	☐Y	☐N
Difficulty Swallowing	☐Y	☐N

Urinary		
Painful Urination	☐Y	☐N
Blood in Urine	☐Y	☐N
Increased Frequency	☐Y	☐N
Loss of Control	☐Y	☐N
Impotence	☐Y	☐N

Gynecological		
Vaginal Discharge	☐Y	☐N
Pelvic Pain	☐Y	☐N
Abnormal Bleeding	☐Y	☐N

Musculoskeletal		
Muscle Pain	☐Y	☐N
Spine Tenderness	☐Y	☐N
Swollen Joints	☐Y	☐N
Joint Redness	☐Y	☐N
Bone Pain	☐Y	☐N

Skin		
Rash	☐Y	☐N
Nodules	☐Y	☐N
Itchiness	☐Y	☐N
Lesions	☐Y	☐N

Neurological		
Confusion	☐Y	☐N
Seizures	☐Y	☐N
Fainting Spells	☐Y	☐N
Tremors	☐Y	☐N
Speech Change	☐Y	☐N
Headache	☐Y	☐N
Abnormal Gait	☐Y	☐N
Weakness	☐Y	☐N
Sensory Change	☐Y	☐N

Psychiatric		
Anxiety	☐Y	☐N
Depression	☐Y	☐N

Endocrine		
Excessive Urine	☐Y	☐N
Excessive Thirst	☐Y	☐N
Hot Flashes	☐Y	☐N
Heat/Cold Intolerance	☐Y	☐N

Hematological		
Nose Bleeds	☐Y	☐N
Bleeding Gums	☐Y	☐N
Easy Bruising	☐Y	☐N

Lymphatic		
Enlarged Lymph Nodes	☐Y	☐N
Swelling in Arms/Legs	☐Y	☐N

Radiation/Chemo History:

Previous Radiation Therapy: ☐ Yes ☐ No If yes, where?_____
Previous Chemotherapy: ☐ Yes ☐ No If yes, where?_____

Patient Preferences:

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? ☐ Yes ☐ No
Do you have a durable power of attorney or a living will? ☐ Yes ☐ No
Do you have a current Advanced Directive? ☐ Yes
☐ No
Are there any language barriers that the staff needs to be aware of? ☐ Yes ☐ No
Do you feel unsafe or threatened by anyone? ☐ Yes ☐ No
Do you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No

REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? _____

Have you ever accessed the VA for any services? Yes or No If so, what services did you use?
_____

Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.

_____
_____
_____
_____
_____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

Current Medication Form

Name: _____
DOB: _____

Pharmacy Name: _____
Address: _____
Phone/Fax: _____

Allergies & Adverse Reactions

Medication	Reaction

Current Medications

Prescription, over-the-counter, and herbal remedies

Medication	Dose	Schedule

Reviewed By: _____ **Date:**_____

SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Acknowledgment of Receipt of Notice of Privacy Practices

Shenandoah Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shenandoah Oncology, P.C.

Printed Name: _____ DOB: _____

Signature: _____

Name of Representative (if appropriate):

_____

Signature of Representative (if appropriate):

_____

Shenandoah Oncology, P.C. Use Only

Date acknowledgement received: _____

OR

Reason acknowledgement was not obtained and employee signature:

_____

_____

Signature:_____

SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

AUTHORIZATION FOR RELEASE OF RECORDS TO SHENANDOAH ONCOLOGY, P.C.

Medical Records Phone: 540-450-0682
Medical Records Fax: 540-667-3408

Date: _____

I hereby authorize Dr. _____to release information from the records of:
(Leave Blank)

_____ _____
Patient Name Street Address

_____ _____
City, State, Zip Code Telephone Number

_____ _____
Date of Birth Signature of Patient

I authorize that the following records may be sent:

- ☐ Physician notes/letters
- ☐ Hospital Records
- ☐ Treatment Records
- ☐ Laboratory and Pathology results
- ☐ Pathology slides & tissue blocks
- ☐ Radiology reports and disks
- ☐ All of the above

SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Authorization of Release of Medical Information

Date: _____

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

_____ _____

Patient Name Street Address

_____ _____

City, State, Zip Code Telephone Number

_____

Date of Birth

_____

Signature of Patient

You may release this information to the following individuals:

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal, offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address [one email address per patient] that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic mail Authorization Form. Please write legibly.

_____ Patient's Name [printed]

_____ Email Address of Patient/Authorized User

_____ Date of Birth of Patient

_____ Physician's Name

Authorized user is:

☐ Patient
☐ Patient's Designee

_____ Patient's Designee's name [Printed]

_____ Patient's medical Record Number

_____ Patient's Designee's Signature

_____ Patient's Signature

_____ Date

_____ Signature of Practice Staff

_____ Date

ATTENTION: If you speak Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindu, German, or Bengali, language assistance services, free of charge, are available to you. Call Tiffany Breeden at 540-662-1108

Atención: Si usted habla español, Coreano, vietnamita, Chino, Árabe, neerlandés, persa, Amharic, Urdu, Francés, Ruso, hindú, alemán, Dengali o Kru, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llamada Tiffany Breed en 540-662-1108

주의: 만약 당신이 말하는 스페인어, 한국어, 베트남어, 중국어, 아랍어, 타갈로그어, 페르시아어, Amhric, Urda, 프랑스어, 러시아어, 힌두교, 독일어, Dengali, 또는 크루, 언어 지원 서비스, 무료로, 당신이 사용할 수 있습니다. 티파니 Breeden 540-662-1108에서 호출

Chú ý: Nếu bạn nói tiếng Tây Ban Nha, Hàn Quốc, Việt Nam, Trung Quốc, tiếng ả Rập, tiếng Tagalog, tiếng Ba tư, Amhric, Urda, Pháp, Nga, Hindu, Đức, Dengali, hoặc Kru, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi Tiffany Breed tại 540-662-1108

c注意： 如果你會說西班牙文、 朝鮮語、 越南、 中國、 阿拉伯文、 他加祿語、 波斯、 Amhric、 Urda、 法國、 俄羅斯、 印度教、 德國、 Dengali 或克魯， 語言援助服務， 免費的是可供您使用。 調用 540-662-1108 蒂凡尼布裡登

تنبيه :إذا كنت أتكلم الإسبانية، والفيتنامية، الصينية الكورية، العربية، التغالوغيه، الفارسي، أمهريك، أردا، الفرنسية، الروسية، الهندوسية، الألمانية، دينجالي، أو كرو، خدمات المساعدة اللغوية، مجاناً، تتوفر لك .دعوة تيفاني بريدين في 1108-662-540

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Tiffany Breeden (540) 662-1108

ትኩረት: እናንተ ስፓንኛ መናገር ከሆነ, ኮሪያኛ, ቬትናምኛ, ቻይንኛ, አረብኛ, ታጋሎግ, የፋርስ, አማርኛ, Urda, ፈረንሳይኛ, ሩሲያኛ, የሂንዱ, ጀርመንኛ, ቤንጋሊ, ወይም Kru, የቋንቋ እርዳታ አገልግሎቶች, ከክፍያ ነፃ, ለእርስዎ የሚገኙ ናቸው. 540-662-1108 ላይ ቲፋኒ Breeden ይደውሉ

توجہ :آپ ہسپانوی، کوریا، ویت نامی، چینی، عربی، تگالوگ، فارس، امہري زبان، یوردا، فرانسیسی، روسی، ہندو، جرمنی، بنگالی یا کرو بات کیجیے تو زبان معاونت خدمات، مفت آپ کو دستیاب ہیں ۔ واپس اوپر واپس بریدان 1108-662-540 پر کال کریں

ATTENTION : Si vous parlez espagnol, coréen, vietnamien, chinois, arabe, Tagalog, persan, amharique, ourdou, Français, russe, hindou, allemand, Bengali ou Kru, services d'assistance linguistique, gratuites, sont à votre disposition. Tiffany Breeden appel à 540-662-1108

ВНИМАНИЕ: Если вы говорите, испанский, корейский, вьетнамский, китайский, арабский, тагальский, Персидский, Турецкий, урду, французский, Русский, индуистской, немецкий, бенгальский или КРУ, языковых служб помощи, бесплатно, доступны для вас. Бриден Tiffany звонка в 540-662-1108

ध्यान दें: यदि आप स्पेनिश, कोरियाई, वियतनामी, चीनी, अरबी, तागालोग, फ़ारसी, अम्हारिक, उर्दू, फ्रेंच, रूसी, हिंदू, जर्मन, बंगाली या Kru के बात, भाषा सहायता सेवाओं, नि: शुल्क, आप के लिए उपलब्ध हैं। टिफ़नी Breeden 540-662-1108 पर कॉल करें

Achtung: Wenn Sie Spanisch, Koreanisch, Vietnamesisch, Chinesisch, Arabisch, Tagalog, Persisch, Amharisch, Urdu, Französisch, Russisch, Hindu, Deutsch, Bengali oder Kru sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie Tiffany Breeden bei 540-662-1108

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