400 Indiana Street
Suite 220
Golden, CO 80401
720-420-3300 phone
720-420-3301 fax

ALLIANCE CANCER CARE COLORADO
at Red Rocks

Patient Name: <Full Name>

Prefers to be called: _____

Date of Birth: <Date of Birth> Patient ID: <Patient Id 1>

Referring Physicians:
<Referring Physicians-Name Only (Default)>

Additional Physicians: _____ _____

Check if you have had: ☐ Previous Radiation ☐ Surgery ☐ Chemotherapy ☐ Hormone Therapy

If you have received radiation previously, when, where, and Physician:_____

Reason you are being seen: _____

_____

Medical History – Check if you have a history of any of the following:

☐ Scleroderma	☐ Lupus	☐ Ulcerative Colitis	☐ Connective Tissue Disease
☐ Crohn's Disease	☐ Tuberculosis	☐ High Blood Pressure	☐ Diabetes (IDOM/NIDOM)
☐ Heart Disease	☐ Heart Attack	☐ Thyroid Problems	☐ Stroke
☐ Seizures	☐ Kidney Disease	☐ Bleeding Disorder/Clotting	☐ Asthma
☐ STD's			

List medical problems:_____

_____

_____

List surgeries, hospitalizations, accidents and injuries:

Year	Description	Year	Description

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RADIATION ONCOLOGY ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

Medication History

Check here if you do not have any known drug allergies - ☐

Allergies – Check and describe your allergic reaction:

Shellfish: ☐ Yes ☐ No Reaction:_____

Iodine: ☐ Yes ☐ No Reaction:_____

Contrast Dye: ☐ Yes ☐ No Reaction:_____

Tape: ☐ Yes ☐ No Reaction:_____

Latex: ☐ Yes ☐ No Reaction:_____

Penicillin: ☐ Yes ☐ No Reaction:_____

Sulfa: ☐ Yes ☐ No Reaction: _____

Other drug allergies: Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

**** VERY IMPORTANT to List all Medications, Vitamins and Herbs. Please Include Dose:**

Medication	Dosage	Frequency	Route

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Social History

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Race: _____ Religion: _____

Persons living in my household: _____

Last school grade completed: _____

Education: _____

Occupation (s): _____

☐ Employed ☐ Unemployed ☐ Disabled

☐ Retired ? If yes, when did you retire? _____

Hobbies, Activities, Interests: _____

Tobacco History

Do you currently smoke: ☐ Yes ☐ No

If YES, how many packs per day? _____, for how many years? _____

If NO, did you smoke in the past? ☐ Yes ☐ No

When did you quit smoking? _____

Do you, or have you used other forms of tobacco (cigars, snuff, etc.)? _____

Alcohol History

Do you drink alcohol? ☐ Yes ☐ No

If YES, what type(s) of alcohol do you drink? _____

How often do you drink? _____

What amount do you drink? _____

Have you ever had a problem with alcohol abuse? ☐ Yes ☐ No

Infectious Disease History

Have you been exposed to HIV virus?	☐ Yes	☐ No
Have you ever had Hepatitis?	☐ Yes	☐ No
Have you engaged in high risk sexual activity?	☐ Yes	☐ No
Have you used intravenous drugs?	☐ Yes	☐ No
Have you been exposed to TB (Tuberculosis)?	☐ Yes	☐ No
Have you had a blood transfusion?	☐ Yes	☐ No

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Family History							
Family Member (list only biological) (If deceased, list age at death)	Age	Deceased	Cancer	Diabetes	High Blood Pressure	Heart Attack	Fill in other major health problems of family member. If deceased, fill in cause of death, include accidents and suicides.
Mother							
Father							
Sister and Brothers							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
☐ Sister ☐ Brother							
Children							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							
☐ Daughter ☐ Son							

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Review of Systems - **Please choose N/A when applicable**

Constitutional ☐ **N/A**

☐ Unusual weight loss, amount _____ ☐ Weight gain, amount _____

☐ Fatigue ☐ Fever ☐ Chill ☐ Night sweats (requiring change of pajamas or sheets).

Blood Disorders ☐ **N/A**

☐ Excessive bruising ☐ Frequent nosebleeds ☐ Gum bleeding ☐ Taking anticlotting drugs

☐ History of bleeding or clotting problems?

Endocrine ☐ **N/A**

☐ Diabetes: ☐ Yes ☐ No If yes, do you require insulin? ☐ Yes ☐ No

☐ Thyroid problems (hyperthyroidism, goiter, hypothyroidism).

☐ Excessive hunger ☐ Excessive thirst ☐ Excessive urination ☐ Heat intolerance

Skin ☐ **N/A** ☐ Rashes ☐ Severe itching ☐ Sores

Head and Neck ☐ **N/A**

Eyes ☐ Glaucoma ☐ Cataracts ☐ Spots ☐ Double vision ☐ Flashing lights ☐ Dry eyes

☐ Glasses ☐ Contacts ☐ Recent Vision Change ☐ Excessive tearing

Ears ☐ Hearing Loss ☐ Ear ache ☐ Dizziness ☐ Ringing/Tinnitus ☐ Sensitivity to noise

Nose ☐ Sinus problems ☐ Frequent colds ☐ Hay fever ☐ Nasal stuffiness ☐ Runny nose

Mouth ☐ Sores ☐ Sore throat ☐ Sore tongue ☐ Dry mouth ☐ Speech problems ☐ Gum bleeding

☐ Denture: Upper _____ Lower _____ ☐ Partial plates: Upper _____ Lower _____

☐ Bridge: Upper _____ Lower _____

Throat ☐ Voice changes ☐ Fullness ☐ Stiffness ☐ Hoarseness ☐ Tenderness or pain

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Cardiovascular and Respiratory ☐ **N/A**

☐ Angina ☐ Swollen feet ☐ Shortness of breath at rest ☐ Heart murmur ☐ Coughing up blood

☐ Chest pain ☐ Pleurisy ☐ Emphysema ☐ Congestive heart failure ☐ Asthma

☐ Bypass surgery ☐ Previous heart attack ☐ Blood clots ☐ Poor circulation ☐ High blood pressure

☐ Palpitations ☐ Rheumatic Fever ☐ Shortness of breath with activity ☐ Wheezing

☐ Chronic bronchitis ☐ History of TB (tuberculosis) ☐ Irregular heart beat/arrhythmia

☐ Oxygen? _____liters/minute ☐ Cough: Productive _____ non-productive _____

☐ Need to sleep with several pillows, otherwise patient becomes short of breath.

Gastrointestinal ☐ **N/A**

☐ Loss of appetite	☐ Liver problems	☐ Regular use of antacids
☐ Constipation	☐ Tea colored urine	☐ Regular use of laxatives
☐ Jaundice	☐ Hemorrhoids	☐ Change in bowel habits
☐ Heartburn	☐ Blood in stools	☐ Pain upon swallowing
☐ Nausea	☐ Abdominal pain	☐ Gallbladder problems
☐ Vomiting	☐ Vomiting of blood	☐ Grayish colored stools
☐ Diarrhea	☐ History of hepatitis	☐ Difficulty swallowing
☐ Indigestion	☐ Black, tarry stools	☐ History of Crohn's disease
☐ Irritable bowel syndrome	☐ Change in color of the stool	☐ Change in shape of the stool
☐ History of ulcerative colitis	☐ Bright red blood from the rectum	

Genitourinary: Male ☐ **N/A**

☐ Urgency ☐ Enlarged prostate ☐ Sores or discharge from penis ☐ Dribbling ☐ Poor urinary flow

☐ Pain or burning with urination ☐ Hernias ☐ Frequent urination

☐ History of bladder or urinary tract infection ☐ Flank pain ☐ Blood in urine

☐ Testicle pain or enlargement or lumps ☐ Kidney stones ☐ hesitancy upon urination

☐ Decreased force of stream ☐ Incontinence ☐ Not able to obtain erection sufficient for intercourse

☐ _____number of times you get up to urinate at night.

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Genitourinary: Female ☐ **N/A**

☐ Dribbling ☐ Frequent urination ☐ Pain or burning with urination ☐ Kidney stones ☐ Blood in urine

☐ Frequent urinary tract infection ☐ Flank pain ☐ Incontinence of urine ☐ Bleeding between periods or after intercourse

_____age at onset of menstrual period _____date of last menstrual period _____number of miscarriages

_____number of pregnancies _____age at first delivery _____age at menopause

_____number of live births _____date of last PAP/pelvic exam ☐ Hormone replacement:_____

Musculoskeletal ☐ **N/A**

☐ Scoliosis ☐ Osteoarthritis ☐ Weakness of arm(s) or leg(s) ☐ Bursitis ☐ Rheumatoid arthritis

☐ Muscle cramps or spasms ☐ Sciatica ☐ Pinched nerve ☐ Surgeries on muscles, joints or bones ☐ Gout

☐ Previous fractures ☐ Injuries to muscles or bones ☐ Tendonitis ☐ Chronic back pain ☐ Dislocations:_____

Neurologic ☐ **N/A**

☐ Headaches ☐ Disorientation ☐ Change in vision ☐ Strokes ☐ Fainting ☐ Loss of coordination ☐ Seizures

☐ Paralysis ☐ Weakness of part of the body ☐ Dizziness ☐ Loss of memory

Have you ever fallen at home? ☐ Yes ☐ No How many times? _____

Reason why you fell? ☐ Tripped ☐ Lost balance ☐ Legs gave out ☐ Fainted ☐ don't know

Do you have problems walking ☐ Yes ☐ No Explain:_____

Do you need a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches

Check if you have problems independently: ☐ Eating ☐ Bathing ☐ Dressing

Do you have the strength and endurance to perform these activities? ☐ Yes ☐ No

Have you ever had any: ☐ Physical Therapy ☐ Occupational Therapy

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Psychiatric

☐ Depression ☐ Manic depression ☐ Schizophrenia ☐ Nervousness ☐ Anxiety

☐ Other mental illness Obsessive-compulsive disorder

Do you have a personal concern about which you would like to talk to someone?_____

Are you worried about how your spouse/children are adjusting?_____

Are finances at a critical point?_____

Do you feel stressed out and overwhelmed by the situation? _____

Would you like to meet with a chaplin?_____

Is cancer causing you to rethink your priorities? _____

Check the description below if it describes you:

☐ Significant change in appetite ☐ Change in sex life

☐ Loss of interest in hobbies ☐ Feeling hopeless

☐ Change in sleeping patterns ☐ Increased use of alcohol

☐ Difficulty in controlling anger ☐ Tendency to isolate or withdraw

☐ Frequent crying spells ☐ Are you restless?

☐ Loss of interest in your job ☐ Difficulty concentrating

☐ Have you had a really good laugh in the past ten days?

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Patient name: <Full Name>

DOB: <Date of Birth>

_____ **Assignments of Benefits**: I authorize payment directly to Alliance Cancer Care at Red Rocks and Mountain Radiation Oncology Consultants, P.C., of all insurance or other health benefits to which I would otherwise be entitled for my entire course of medical care and services.

_____ **Release of Information**: I authorize release of necessary information from my medical record for the purpose of insurance claim payment(s), treatment authorizations, and my continuing medical care.

_____ **Financial Agreement**: I understand that I am responsible for and agree to pay all charges and/or expenses rendered which are not covered by my insurance and are deemed my responsibility per my insurance policy (co-pays, co-insurance, deductibles, out-of-pocket expenses, etc.).

_____ **Privacy Notice Acknowledgment**: I hereby acknowledge receipt of the Notice of Privacy Practices given to me by Alliance Cancer Care at Red Rocks. If not initialed, reason why acknowledgement was not obtained:

_____

_____ **Consent to Leave Information**: I authorize Alliance Cancer Care at Red Rocks and Mountain Radiation Oncology Consultants, P.C. to release information regarding my care as follows:

Primary Care Physician
Provider:_____

☐ Leave information on my voice mail answering machine on the following:
☐ Home ☐ Cell# ☐ Work# (listed on current demographic form)

☐ Leave information regarding my care and/or financial information with the following family members and/or individuals – not physicians or medical professionals.

Name: _____ Relationship: _____

Phone: _____

☐ **Emergency Contact:** Contact the following person in the case of an emergency only:

Name: _____ Relationship: _____

Phone: _____

_____ Date _____

Signature of Patient/Guardian/Representative

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Instructions to Patient

1. Please fully complete, sign and date this form.
2. Please return this form to the Alliance location where services are performed.

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by Alliance HealthCare Services or one of its subsidiaries of affiliates (collectively, "Alliance"). I agree that I will contact Alliance's Privacy Official with any questions that I may have concerning the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

In the event the patient declines acknowledgement of receipt of Alliance's Notice of Practices, Please describe below the good faith efforts used to obtain such acknowledgement and the reason why the acknowledgement was not obtained:

_____
_____
_____
_____

Signature: _____

Name: _____

Title: _____

Date: _____

Instructions to Service Location

After completion, please return this form to the applicable Centralized Billing Office (i.e., Canton or Andover office) for processing.