Florida Oncology Tavares
RADIATION TREATMENT CENTER

NEW PATIENT FORMS

(Please Print. Thank You.)

Patient Name: _____ **Date of birth:** _____

Address: _____ **Social Security Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

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

Email Address: _____

Secondary Address: _____
City: _____ State: _____ Zip Code: _____

Race: ☐White ☐Hispanic/Latino ☐Black/African American ☐Native American
☐Asian/Pacific Islander ☐Other

EMERGENCY CONTACT (PARENT/GUARDIAN IF PATIENT IS A MINOR)

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Power of Attorney (if applicable): _____**Relation to You:** _____

Living Will: ☐Yes ☐No *Please provide a copy for your record

I certify that the information I will give today is to the best of my ability and as fully accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
PATIENT LEGAL GUARDIAN/REPRESENTATIVE OR PARENT **DATE**

REASON FOR THIS VISIT: _____

CLINICAL INFORMATION:

Primary Care Physician: _____ City, State: _____

Referring Physician: _____ City, State: _____

Please list any additional Physicians you see -	Specialty	- City, State
	-	-
	-	-
	-	-
	-	-

INSURANCE:

Primary Insurance Carrier: _____

Policy ID**: _____** Policy Group #: **_____**

Name of primary policy holder (If not patient): **_____**

Policy holder's Date of Birth: **_____Does plan have prescription coverage?** ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Policy ID: **_____** Policy Group #: _____

Name of secondary policy holder (If not patient): **_____**

Policy holder's Date of Birth: _____**Does plan have prescription coverage?** ☐ Yes ☐ No

PREFERED PHARMACY AND LABORATORY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Where do you normally get your lab work done?

☐ LabCorp ☐ Quest ☐ Other: _____

Patient Initial _____

CANCER HISTORY:

Type: _____ **Date Diagnosed:** _____

Previous Radiation Therapy ☐ Yes ☐ No **Treatment Physician:** _____

Treatment Facility**:** _____ Treatment Date**:** _____

Previous Chemotherapy ☐ Yes ☐ No **Treatment Physician:** _____

Treatment Facility**:** _____ Treatment Date: _____

Previous Cancer Surgery ☐ Yes ☐ No **Surgeon:** _____

Surgery Facility**:** _____ Surgery Date: _____

Recent Diagnostic Scans:

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

PAST SURGICAL HISTORY:

Port Placement	Date: _____	Coronary Bypass	Date: _____
Mastectomy	Date: _____	Angioplasty	Date: _____
Lumpectomy	Date: _____	Cardiac Valve surgery	Date: _____
Hysterectomy	Date: _____	Rotator Cuff Repair	Date: _____
Oophorectomy	Date: _____	Knee Replacement	Date: _____
Tubal ligation	Date: _____	Hip Replacement	Date: _____
TURP	Date: _____	Cataract	Date: _____
Prostatectomy	Date: _____	Gallbladder surgery	Date: _____
Focal Laser Ablation	Date: _____	Hemorrhoidectomy	Date: _____
HIFU	Date: _____	Hernia Repair	Date: _____
Vasectomy	Date: _____	Appendectomy	Date: _____
Thyroidectomy	Date: _____	Tonsillectomy	Date: _____

Other Operations:

_____

	YES	NO
Do you have a pacemaker?		

Pacemaker Placement Date (please provide copy of the card for your record): _____

Manufacturer: _____ Last Pacer Check:_____ _____

Managing Cardiologist: _____

Other Stimulator Type: _____ Placement Date:_____

Patient Initial _____

MEDICAL HISTORY: (Check the items that apply to you, currently or in the past)

- ☐ None
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Disorder
- ☐ Frequent infections
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
  - ☐ Hypothyroid (Low)
  - ☐ Hyperthyroid (High)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Attack-MI
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia
- ☐ TB (Tuberculosis)
- ☐ COVID-19 Infection Date:_____
- ☐ Sleep Apnea
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcers
- ☐ GERD/Heartburn/Reflux
- ☐ Hiatal Hernia
- ☐ Gallstones
- ☐ Cirrhosis of Liver
- ☐ Hepatitis A /B / C
- ☐ Pancreatitis
- ☐ Freq. Urinary Tract infection
- ☐ Kidney Stone
- ☐ Kidney Disease/Failure
- ☐ Enlarged Prostate
- ☐ Osteoarthritis
- ☐ Chronic Back Pain
- ☐ Osteoporosis
- ☐ Fracture
- ☐ Stroke
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Paralysis
- ☐ Seizures
- ☐ Migraines
- ☐ Claustrophobia
- ☐ Autoimmune Disease
  - ☐ Rheumatoid Arthritis
  - ☐ Lupus
  - ☐ Scleroderma
  - ☐ Fibromyalgia
  - ☐ Raynaud's Syndrome
  - ☐ Myasthenia Gravis
  - ☐ Psoriasis
  - ☐ Multiple Sclerosis
- ☐ Shingles
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Anxiety
- ☐ Depression
- ☐ Drug Use
- ☐ Problems w/Anesthesia
- ☐ Keloid History
- ☐ Other Medical Conditions

_____

HEALTH MAINTENANCE:

Sigmoidoscopy / Colonoscopy Date: _____ Findings: _____

Last Mammogram Date: _____ Findings: _____

Last Pelvic Exam Date: _____ Findings: _____

Last EGD Date: _____ Findings: _____

Influenza (Flu) Vaccine Date: _____ Pneumococcal Vaccine Date: _____

Last Shingles Vaccine Date: _____ COVID-19 Vaccine Date[s]: _____

OB-GYN HISTORY (Women Only):

Number of pregnancies: _____ Number of children born: _____

Last menstrual period:_____ Hormone replacement therapy use?_____

If yes, how long? _____

Patient Initial _____

MEDICATION LIST: Your treatment can be affected by any medication that you take. It is important that your physician has updated and correct information.

List **ALL** medications (including non-prescription) that you are currently taking:

Medication	Dose/Frequency	Reason	Ordering Physician

ALLERGIES: List all medication allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye / IV Contrast ☐ Eggs ☐ Peanuts

Other:_____

Type of reaction: _____

Patient Initial _____

SOCIAL HISTORY:

Birth City: _____ Birth State: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Children: ☐ Yes ☐ No Number of Children: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired

Retired Date: _____

Occupation (Former if Retired): _____

Employer (Former if Retired): _____

Tobacco Use: (Present &/or Past)

☐ Never Smoked

☐ Quit Smoking When? _____ How many years did you smoke? ____yr(s) How many packs? ___/day

☐ Currently Smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Vape

Alcohol Use:

☐ Non-Drinker

☐ Beer number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Wine number of glasses _____ per ☐ Day ☐ Week ☐ Month

☐ Liquor number of glasses _____ per ☐ Day ☐ Week ☐ Month

Military History:

Have you ever served in the military? ☐ Yes ☐ No Years in service: _____

Service branch and duties: _____

Agent Orange Exposure ☐ Yes ☐ No

FAMILY MEDICAL HISTORY: (Indicate any family members with cancer)

Relation	Age at Cancer Diagnosis	Cancer History	If deceased, Age and cause of death
Father			
Mother			
Siblings			
Children			
Paternal Aunts			
Maternal Aunts			
Paternal Uncles			
Maternal Uncles			
Paternal Grandparents			
Maternal Grandparents			

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No

Please list: _____

Patient Initial _____

REVIEW OF SYSTEMS:
(Please check any **current** symptoms you have.)

General:
- ☐ Weight loss
  How much_____
  Over what time period _____
- ☐ Fevers
  Max temp _____
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred Vision
- ☐ Double Vision

Ears, Nose, Throat:
- ☐ Hard of hearing or deaf
- ☐ Ringing in ears
- ☐ Enlarged lymph nodes
- ☐ Chronic sinus problems
- ☐ Sore throat
- ☐ Mouth pain/sores

Changes/Difficulty In:
- ☐ Taste
- ☐ Smell
- ☐ Voice

Cardiovascular:
- ☐ Chest pain/Angina Pectoris
- ☐ Palpitations/heart murmur
- ☐ Irregular heartbeat pressure

Respiratory:
- ☐ Chronic or Frequent Cough
- ☐ Bloody Sputum
- ☐ Shortness of breath

Gastrointestinal:
- ☐ Difficult or painful swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Lump or sensation in throat
- ☐ Food Sticking
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Black or tarry stools
- ☐ Blood in stool
- ☐ Excessive rectal gas/flatus
- ☐ Loss of stool/fecal accident
- ☐ Poor appetite
- ☐ Jaundice

Genitourinary:
- ☐ Kidney Stones
- ☐ Pelvic Pain
- ☐ Incontinence
- ☐ Burning or pain in urination
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination

Musculoskeletal:
- ☐ Joint Pain/Arthritis
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle aches

Neurologic:
- ☐ Numbness, tingling
- ☐ Arm or leg weakness
- ☐ Light-headed, dizzy, fainting spells
- ☐ Headache

Skin:
- ☐ Rashes or itching
- ☐ Change in skin color or moles
- ☐ Varicose vein
- ☐ Skin Cancer If so, where?_____

Psychiatric:
- ☐ Anxiety/Agitation
- ☐ Depression
- ☐ Crying for no reason
- ☐ Insomnia
- ☐ Alcoholism
- ☐ Drug Problem (Now/Past)

Hematologic:
- ☐ Easy bruising
- ☐ Gum or nose bleeding
- ☐ Blood transfusion in the past

Allergies/Immunology:
- ☐ History of chronic infections
- ☐ History of allergies

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Weight problem
- ☐ Hot flashes

Gynecologic:
- ☐ Breast pain/lump
- ☐ Breast discharge or rash
- ☐ Vaginal discharge
- ☐ Menstrual irregularity
- ☐ Abnormal Vaginal bleeding

Patient Initial _____