

# Robert Boissoneault Oncology Institute Patient Registration

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Physician Information	
Referring Physician:	_____
Primary Physician:	_____
Other Physicians:	
_____	

The following information is required by the State of Florida:

Race:  American Indian / Eskimo / Aleut  Black  White Hispanic  Other  
 Asian / Pacific Islander  White  Black Hispanic  No Response

Your Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's SSN#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

List your e-mail address if interested in receiving notice of seminars, etc. \_\_\_\_\_

How did you hear about RBOI?

Referring Doctor  Newspaper  Phone Book Other: \_\_\_\_\_

While under the care of the physicians at the Robert Boissoneault Oncology Institute, I hereby give authorization for the release of private health related information to the following authorized persons:

Physicians	Family Members (Relation)

This information may be given to the above mentioned people either by phone, fax machine, or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named persons, I will notify RBOI in writing of such names.

I authorize RBOI and staff to leave medical information pertaining to my care using the following methods and will assume responsibility to notify RBOI and staff whenever this information changes:

- Home Telephone                     YES       NO
- Answering Machine         YES       NO
- Work Telephone                    YES       NO
- Voice-Mail                     YES       NO
- Cell Phone and/or                 YES       NO
- Voice-Mail                     YES       NO
- Pager                                 YES       NO

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Do you have or have you had any of the following conditions?

Check One

Year Diagnosed

Cancer (other than for this visit) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Heart Disease .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
High Blood Pressure .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Pacemaker .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Reflux or GERD .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Stomach Ulcers .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Diabetes .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Arthritis .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Stroke .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Lung Disease ( <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> pneumonia) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Prostate Disease .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Bladder Disease .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Kidney Disease .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Liver Disease .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Seizures .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Mental Illness (nervous condition / depression) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Other serious medical condition: .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Are you allergic to any medications? If yes, please list: .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

When?

Any other notable allergies? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Have you had any major accidents or injuries? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Have you had a colonoscopy? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Do you have a DNR (Do not resuscitate) order? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Do you have a Living Will? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Past Surgical History

List all major operations you have had:

Date

_____	_____
_____	_____
_____	_____
_____	_____

Cancer Treatment History

Have you ever had radiation or x-ray treatments? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Area of body: _____ Facility and city where treated: _____			
Have you ever had chemotherapy? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Prostate Screening (Males)

Recent PSA and/or digital rectal exam? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Do you have a family history of prostate cancer? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Gynecological History (Females)

Is there any chance you could be pregnant? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Number of pregnancies: _____ Number of live births: _____			
Age at first pregnancy: _____ Did you breast feed? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Date of last mammogram: _____ Date of last pap smear: _____			
Have you ever taken birth control pills? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Have you ever taken hormone replacement therapy? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Onset of menstruation (age): _____ Age at menopause: _____			
Do you have a family history of breast cancer? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Who? _____

# Family History

Relation                      Age                      State of Health                      If deceased, cause and age of death

Mother .....

Father .....

Siblings: .....

.....

Spouse .....

Children .....

Have you ever used tobacco products?                       Yes     No  
Type? \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_ Date Quit? \_\_\_\_\_

Do you drink alcoholic beverages?                       Yes     No  
Type? \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_ Date Quit? \_\_\_\_\_

## Review of Systems

Have you experienced any of these problems during the past month?

Yes     No    Weight Loss (if yes, how many pounds have you lost?) \_\_\_\_\_

Yes     No    Fevers                       Yes     No    Vomiting

Yes     No    Chills                       Yes     No    Diarrhea

Yes     No    Skin rash or itching                       Yes     No    Constipation

Yes     No    Headaches                       Yes     No    Jaundice

Yes     No    Seizures                       Yes     No    Rectal bleeding

Yes     No    Loss of balance or coordination                       Yes     No    Blood in urine

Yes     No    Hearing loss

Yes     No    Vision: blurred, double, loss

### For Men

Yes     No    Arm or leg paralysis                       Yes     No    Decrease in size or force of urine stream

Yes     No    Arm or leg numbness                       Yes     No    Difficulty with sex or impotence

Yes     No    Difficulty swallowing

### For Women

Yes     No    Hoarseness or change in voice                       Yes     No    Lump, discharge or breast pain

Yes     No    Sores in mouth or lip                       Yes     No    Irregular menstrual bleeding

Yes     No    Shortness of breath                       Yes     No    Irregular vaginal bleeding or discharge

Yes     No    Cough                       Yes     No    Difficulty with sex or painful intercourse

Yes     No    Coughed or spit up blood

Yes     No    Mood changes or depression

Yes     No    Frequent indigestion

Yes     No    Nausea

## Pain

Do you have any pain? If yes, what is the severity on a scale of 1 – 10 (10 being the worst)? \_\_\_\_\_

Location: \_\_\_\_\_

Describe the pain:     Constant     Intermittent     Shooting     Throbbing

Dull     Sharp     Burning    Other: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Does medication relieve the pain?                       Yes     No

\_\_\_\_\_  
Patient or nearest of kin

## Office Use Only

\_\_\_\_\_  
Relationship to Patient

Karnofsky Scale: \_\_\_\_\_

Date: \_\_\_\_\_