ANOVA cancer care

NEW PATIENT INTAKE - ADULT FORM

Welcome to Denver Cyberknife (DBA Anova Cancer Care). This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Chart: _____ **Date**_____

Name: _____ **Nickname:** _____ **D.O.B:** _____ Age: ____

Address (Street, City, State,Zip) _____

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

Social Security#: _____ **Marital Status:** _____ **Email:** _____

Emergency Contact: _____ **Relation to Patient:** _____

Home: _____ **Cell:** _____ **Work:** _____

Referring Dr. _____ **Primary Care Dr.** _____

Required Fields: ☐ Not Reporting **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: _____ **Race:** _____

PHARMACY Name, Address, Phone _____

PERSONAL/PAST MEDICAL HISTORY Height: _____ ft _____in Weight: _____ lbs

Can you have an MRI scan? Yes No What cancer(s) have you been diagnosed with?_____

Hospitalized in the last 10 yrs? Yes No Previous Chemotherapy? Radiation therapy?_____

___ Arthritis
___ Back Pain
___ Bladder Prolapse
___ Colon Problems
___ Diabetes Mellitus
___ Difficulty Urinating
___ Emphysema
___ Gastric Reflux
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ Hernia
___ Hypertension
___ Kidney Failure
___ Kidney Stone
___ Liver Disease
___ Neuropathy
___ Pacemaker
___ Seizure Disorder
___ Stroke/TIA
___ Thyroid Problems
___ Thyroid Disease
___ Urinary Tract Infections
___ Ulcers

Other Medical Problems:
_____
_____

FEMALE PT's ONLY:
___ Uterine Prolapse
___ Vaginal Prolapse
___ Total Hysterectomy
___ Partial Hysterectomy
___ Abnormal Periods

MALE PT"s ONLY:
___ Erectile Dysfunction
___ Penile Discharge
___ Testicular Pain
___ Testicular Mass
___ Spermatocele
___ Hydrocele
___ Hypogonadism

PAST SURGICAL HISTORY

___ Brain
___ Sinus
___ Thyroid
___ Lung
___ Hernia
___ Breast
___ Gall Bladder
___ Intestine
___ Stomach
___ Appendix
___ Pancreas
___ Kidney
___ Bladder
___ Uterus
___ Fallopian Tubes
___ Ovaries
___ Prostate
___ Testes
___ Penis
___ Vasectomy
___ Back

___ Other Surgeries: _____

Do you have any replacement Joints? __ No __ Yes:
___ Hip ___ Knee ___ Shoulder *Heart* ___valves __stents

Please give details of past surgeries checked

_____

_____

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PATIENT:_____

CURRENT MEDICATIONS ___ None
(Please list your dose with each medication)

ALLERGIES ___ No known medication allergies
(Please list the associated symptoms)

SOCIAL HISTORY

Alcohol Use? No Yes- How much?_____ Recreational Drugs? No Yes- How much?_____

Tobacco Use? ___ Never Smoked ___ Smoker: _____ packs per day ___ Former Smoker: quit _____ years ago

FAMILY HISTORY (please indicate family member diagnosed with the following)

M – mother, F - father, S – sister, B - brother, MG – maternal grandparent, PG – paternal grandparent

____ Bladder Cancer
____ Brain Cancer
____ Breast Cancer
____ Kidney Cancer
____ Lung Cancer
____ Prostate Cancer
____ Testicular Cancer
____ Other Cancers
_____
_____
____ Diabetes
____ Heart Disease
____ Hypertension
____ Stroke
____ Obesity
____ Blood Disorder
____ Other _____
_____

REVIEW OF SYSTEMS No symptoms at this time____

___ Sleep Pattern
___ Appetite
___ Bowels
___ Energy Level
___ Physical Activity
___ Rashes
___ Abnormal Lumps
___ Abnormal Skin Color
___ Brain Injuries
___ Head Trauma
___ Loss of Consciousness
___ Headaches
___ Double Vision
___ Eye Discharge
___ Eye Pain or Itching
___ Flashes of Light
___ Sensitive to Light
___ Vision Change/Loss
___ Ear Pain
___ Ear Ringing
___ Hearing Loss
___ Facial Pain
___ Nosebleeds
___ Difficulty Swallowing
___ Difficulty Breathing
___ Coughing
___ Wheezing
___ Shortness of Breath
___ Chest Pains
___ Abnormal Heart Beats
___ Swelling of limbs
___ Discomfort breathing
___ Stents
___ Pacemaker
___ High blood pressure
___ Abdominal Pain
___ Abdominal Pain
___ Vomiting
___ Diarrhea
___ Ongoing Constipation
___ GERD / Indigestion
___ Blood in Urine
___ Painful Urination
___ Excessive Urination
___ Urinary Urgency
___ Urination at night
___ Muscle Pain
___ Muscle Weakness
___ Swollen or Sore joints
___ Arthritis
___ Neuropathy / Pain
___ Weakness
___ Balance
___ Confusion
___ Numbness or Tingling
___ Speech problems
___ Falling
___ Dizziness
___ Anxiety
___ Depression
___ Claustrophobia
___ Diabetes
___ Thyroid Problems
___ Blood Clots
___ Easy Bruising
___ Enlarged Lymph Nodes
___ Pain (explain)
_____

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PATIENT:_____

HIPAA NOTICE ACKNOWLEDGEMENT

The Practice of Denver Cyberknife (DBA Anova Cancer Care) is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operations without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or to remind you of medical appointments. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive the Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.anovacancercare.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Denver Cyberknife (DBA Anova Cancer Care.

FINANCIAL SERVICE AGREEMENT

BILLING PRACTICES: Our policy is to bill the patient's insurance company for service rendered. However, Insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co-insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable. ***Please Note: Professional services provided by Gregg Dickerson, M.D. are billed through Urology Associates, P.C.**

COLLECTION ACTIVITY: Any account balance(s) that are not paid within ninety (90) days from the date of service may be forwarded to a collection agency. If deemed necessary, Denver Cyberknife (DBA Anova Cancer Care) reserves the right to forward the account balance(s) to a collection agency prior to ninety (90) days from the date of service. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

PAYMENT FOR SERVICES: For payment of your financial obligation we accept Cash, Check, Visa, MasterCard or Discover.

If you have any questions or concerns, please speak with the billing dept. at (303)733-0662. ***Please note:*** *It is the patient's responsibility to understand their individual insurance benefits.*

I hereby assign to Denver Cyberknife (DBA Anova Cancer Care) all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider named above to release my medical records and all medical information requested by my insurance company.

Patient/Legal Guardian Signature **Date** **Relation to Patient**

CONSENT TO CONTACT/LEAVE INFORMATION

I authorize the staff of Anova Cancer Care to speak with or leave a message regarding my results with the following individuals:

Name	Relation to Patient	Phone Number	Speak with	Message/VM
Name	Relation to Patient	Phone Number	Speak with	Message/VM
Name	Relation to Patient	Phone Number	Speak with	Message/VM

Patient/Legal Guardian Signature **Date** **Relation to Patient**

Date:_____

Chart #:_____

Name:_____

Urine Leakage (Incontinence) **Inventory:** Please circle one

1 = No leakage

2 = Mild (a few drops a day, no pad use)

3 = Mild (more than a few drops a day, 1-2 pad/day)

4 = Moderate (3 or more pads per day)

5 = Severe leakage problems

Bowel Health Inventory: Please circle one

0 = No problems, no rectal bleeding, less than 5 bowel movements per day

1 = Any or All of the following
- Mild diarrhea
- Mild cramping
- More than 5 bowel movements daily
- Slight rectal discharge or bleeding

2 = Any or All of the following
- Moderate diarrhea and cramping
- More than 5 bowel movements daily
- Rectal mucus discharge
- Intermittent bleeding

3 = Obstruction or rectal bleeding, requiring surgery

4 = Necrosis / Bowel perforation / Fistula

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Phone: 303-396-1400 Fax: 303-648-4697 www.anovacancercare.com

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International Prostate Symptom Score (IPSS)

Date:_____

Chart #:_____

Name:_____

Circle the answer that best describes your symptoms

Urinary symptoms during the past 48 hours	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
1. How often have you had a sensation of not emptying your bladder completely?	**0**	**1**	**2**	**3**	**4**	**5**
2. How often did you urinate more than once within a 2-hour period?	**0**	**1**	**2**	**3**	**4**	**5**
3. How often have you stopped and started several times while urinating?	**0**	**1**	**2**	**3**	**4**	**5**
4. How often had you had difficulty postponing urination?	**0**	**1**	**2**	**3**	**4**	**5**
5. How often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
6. How often did you strain to begin to urinate?	**0**	**1**	**2**	**3**	**4**	**5**

7. How many times did you get up during the night to urinate?	**0** Times	**1** Time	**2** Times	**3** Times	**4** Times	**5** Times

Total Score: _____

Quality of life due to urinary symptoms:

If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?

☐ 0- Delighted ☐ 1 - Pleased ☐ 2 - Mostly Satisfied ☐ 3 - Mixed about it

☐ 4 - Mostly dissatisfied ☐ 5 - Unhappy ☐ 6 - Terrible

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

Patient: _____ **Chart #:** _____ **Date**: _____

Patient Instructions: Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor. Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please, be sure that you select one and only one response for each question.

Are you currently sexually active? YES NO

How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

No Sexual Activity	Never	Few Times	Some Times	Most Times	Almost Always
0	1	2	3	4	5

During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?

Did not attempt intercourse	Never	Few Times	Some Times	Most Times	Almost Always
0	1	2	3	4	5

During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extreme Difficulty	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	2	3	4	5

When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt intercourse	Almost Never	A Few Times	Some Times	Most Times	Almost Always
0	1	2	3	4	5

***Add the numbers for questions 1-5** **Total score:** _____

Total score: 1-7 Severe ED	8-11 Moderate ED	12-16 Mild to Moderate ED	17-21 Mild ED

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