South Florida Cancer Care

[Patient Registration/Information]

(Please Print)

Last Name: First Name:

Date of Birth:

SSN:

Address:

City: State: Zip:

Phone (Home): Phone (Mobile):

Employer: Phone (work):

Emergency Contact Name: Phone:

Relationship:

Primary Doctor / Referring Doctor:

Doctor's Address/Phone:

[Insurance Information]

Primary Insurance: Policy Number:

Name of Policy Holder: Group Number:

I authorize realease of any medical information/records necessary to process your insurance claims and/or as requested by my doctor. I hereby assume financial responsibility for all services rendered.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and or your diagnosis including treatment, payment, and other general health care concerns.

Patient Signature Date

South Florida Cancer Care

[Patient Information/History]

(Please Print)

Last Name: First Name:

Personal history: *(Check all that apply)*

General: ☐ Fevers ☐ Chills ☐ Sweats ☐ Anorexia ☐ Fatigue ☐ Malaise ☐ Weight Loss
☐ Functional Status ☐ Sleep > 8 hrs ☐ Sleep < 8 hrs

Skin: ☐ Rash ☐ Itching ☐ Prior Melanoma ☐ Bleeding ☐ N/A

Eyes: ☐ Blurring ☐ Double Vision ☐ Irratation ☐ Discharge ☐ Eye Pain ☐ Cataracts
☐ Surgery ☐ Vision Loss ☐ N/A

Breasts: ☐ Mass(es) ☐ Pain ☐ Discharge ☐ Prior Biopsy ☐ N/A
Date of Last Mammogram: ☐ Not Done

Prior Breast Biopsy(s):

Respiratory/Cardiac: ☐ Poor Exercise tolerance ☐ Dyspnea ☐ Wheezing ☐ Cough ☐ Prior Heart Attack
☐ Sputum Production ☐ Bloody Cough ☐ Edema ☐ Chest Pain ☐ Cyanosis ☐ Palpitations
☐ Leg Pain ☐ Leg Ulcers ☐ Vertigo ☐ N/A
Last Chest X-Ray: ☐ Not Done

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Change In Bowel Habits
☐ Abdominal Pain ☐ Blood In Stool ☐ Bright Red Blood Per Rectum ☐ Jaundice
☐ Prior Kidney Stones ☐ N/A
Last Colonoscopy: ☐ Not Done

Genitourinary: ☐ Painful Urination ☐ Blood In Urine ☐ Discharge ☐ Frequency
☐ Pap Smear (date done):
☐ Hesitancy ☐ Nocturia ☐ Incontinence ☐ Genital Sores ☐ Impotence ☐ Kidney Stones
☐ Sexual Problems ☐ N/A
☐ Sexual Menstruating (If yes, number of days):
☐ If no, date of last menstruation:

Musculskelital: ☐ Back Pain ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Cramps ☐ Muscle Weakness
☐ Stiffness ☐ Arthritis ☐ Gout ☐ N/A
Last Bone Scan: Last CT Scan/MRI:

Neurologic: ☐ Seizure ☐ Syncope ☐ Stroke ☐ Weakness ☐ Spasms ☐ Tremor ☐ Involuntary Movements
☐ Abnormal Gait ☐ In Coordination ☐ Pain ☐ Change In Sensation
☐ Numbness Of Extremities ☐ Incontinence ☐ N/A

Psychiatric: ☐ Depression ☐ Anxiety ☐ Memory Loss ☐ Mental Disturbance ☐ Suicidal Ideation
☐ Hallucinations ☐ Paranoia ☐ N/A

Endocrine: ☐ Cold and/or Heat Intolerance ☐ Excess or Frequent Urination ☐ Tremor
☐ 10 lb. Weight Gain or Loss in the Last Month ☐ Thyroid Disease ☐ N/A

Hem/One: ☐ Abnormal Bruising ☐ Bleeding ☐ Enlarged Lymph Nodes ☐ Anemia
☐ Blood Transfusions ☐ Prior Cancer ☐ Prior Blood Clots ☐ N/A
Last Blood Transfusion:

Allergic Reactions: ☐ Hives ☐ Eczema ☐ Hay Fever ☐ Persistent Infections ☐ N/A

Allergies:

Personal History: ☐ HIV ☐ Tuberculosis ☐ Pneumonia ☐ Diabetes ☐ High Blood Pressure
☐ Blood Disease ☐ Heart Disease ☐ Liver Disease ☐ Neurologic Disorders

Medications: List all medications you are currently taking.
Include ALL medications, even those over the counter (OTC):

List al Illnesses, Injuries and Operations:

Family History: Please list all blood relatives with their current health (age) or cause of death:

Father:

Mother:

Brother(s):

Sister(s):

Child(ren):

Social History: *(check all that apply)*
☐ Smoking ☐ Alcohol ☐ Caffeine ☐ Aspirin ☐ Coffee ☐ Vitamins ☐ Antacids
☐ Misc Drugs ☐ Other: