CancerCare SPECIALISTS OF ILLINOIS

PATIENT REGISTRATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information (Please use legal name)

Last Name	Maiden Name *(or other last name)*	First Name	Middle Initial
Street Address	City/State/Zip Code		Social Security #
Home Phone # Cell Phone #	Date of Birth	Race / Ethnicity	Gender *(circle one)* Male Female Other
Email Address	Emergency Contact	Relationship	Emergency Contact Number
Spouse's Name	Spouse's SSN #	Phone Number	Date of Birth
Employment Status *(circle one)* Full Time Part Time Student Not Employed Disabled Retired Retirement Date_____		Marital Status *(circle one)* Single Married Widowed Divorced Legally Separated	

Employer Information

Name	Work Number	Occupation
Address	City/State/Zip Code	

Referred By

Referred By:	Address	Phone
Primary Care Physician	Address	Phone

Insurance Information

Primary Insurance	Policy ID #	Employer Name and Group #
Primary Insurance Cardholder Name	Cardholder Date of Birth	Social Security # of Cardholder
Secondary Insurance	Policy ID #	Employer Name and Group #
Secondary Insurance Cardholder Name	Cardholder Date of Birth	Social Security # of Cardholder
Do you have VA Benefits? *(circle one)* Yes No	Do you want the VA to be contacted for authorization? (circle one) Yes No	

Subscriber Information (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security #	Address	City/State/Zip
Phone Number	Employer's Name	Work Number

I hereby authorize Cancer Care Specialists of Illinois and its representatives to provide services to me and I authorize release of any medical and other pertinent information for the purpose of treatment and processing of my health insurance claims. I also authorize direct payment by my insurance to the Cancer Care Specialists of Illinois and understand that I am responsible for payment of all services, including: deductible, co-payments and non-covered services. I understand and agree that I am responsible for any balance for services rendered regardless of my insurance status. I verify that the information provided here is accurate and I will notify the office immediately of any changes.

Signature of Patient or Authorized Representative	**Date**

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MEDICATION LIST

Patient_____ **DOB**_____

Name and location of Pharmacy you use:_____

Please list all known **ALLERGIES AND REACTIONS** (include medications, food, seasonal, etc.)

☐ **No allergies**

Allergy to	Type of Reaction

Please list all **CURRENT** medications you are taking (include vitamins, supplements, nutritional and anything over the counter). □ **No medications**

Name of Medication	Dose	How many times per day?	Prescribing Physican

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HEALTH HISTORY

Patient_____ **DOB**_____

Tell us about your other medical problems and past surgeries

Date	Condition or Surgery	Date	Condition or Surgery

Social History

Do you smoke or use tobacco? □ No □ Quit □ Yes - How much?_____ Since what age?_____
When did you quit?_____ What type? *(Circle One)* Cigarettes Cigars Chewing Tobacco E-Cigarettes
How much alcohol do you drink? (include beer & wine)_____ How Often?_____
How much caffeine do you use? Form_____ Frequency_____
Do you/have you used recreational drugs? Form_____ Frequency_____
Do you have a Living Will? □ No □ Yes Power of Attorney for healthcare? □ No □ Yes Who_____
Do you exercise regularly? □ No □ Yes Explain_____
Do you have a special diet? □ No □ Yes Explain_____
Highest level of Education_____ Past Occupation_____
Are you exposed to any health hazards? □No □Yes Explain_____

Have you had any of the following tests performed in the past year?

Test	Yes	No	Date	Where?	Ordered by?
Recent Blood work					
Bone scan					
PET scan					
Recent CT scan					
Recent MRI					
Recent Sonogram (ultrasound)					

Have you ever had a colonoscopy? □ No □ Yes If so, date of last one performed _____

Family History (if applicable)

Relationship	Age	Alive or Deceased	Any medical issues or cause of death if applicable
Mother		□ Alive □ Deceased	
Father		□ Alive □ Deceased	
Sister(s)		□ Alive □ Deceased	
		□ Alive □ Deceased	
Brother(s)		□ Alive □ Deceased	
		□ Alive □ Deceased	
Children		□ Alive □ Deceased	
		□ Alive □ Deceased	
		□ Alive □ Deceased	
		□ Alive □ Deceased	

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HEALTH HISTORY

Patient_____ **DOB**_____

Please complete each line

CONDITION	YES	NO
Fever	□	□
Weight Loss	□	□
Weight Gain	□	□
Poor Appetite	□	□
Night Sweats	□	□
Chills	□	□
Fatigue	□	□
Change in Vision	□	□
Ringing in Ears	□	□
Mouth Sores	□	□
Pain in Mouth	□	□
Difficulty Swallowing	□	□
New Dental Problems	□	□
Sore Throat	□	□
Swollen Glands	□	□
Chest Pain	□	□
Palpitations	□	□
Irregular/Pounding Pulse	□	□
Shortness of Breath	□	□
Cough	□	□
Cough with Phlegm	□	□
Cough with Blood	□	□
Difficulty Falling Asleep	□	□
Difficulty Staying Asleep	□	□
Difficulty Staying Awake	□	□
Dizziness	□	□

CONDITION	YES	NO
Swelling of Hands or Feet	□	□
Abdominal Pain	□	□
Nausea	□	□
Vomiting	□	□
Heartburn	□	□
Diarrhea	□	□
Constipation	□	□
Rectal Bleeding	□	□
Black Stools	□	□
Change in Urination	□	□
Bone Pain	□	□
Back Pain	□	□
Joint Pain	□	□
Muscle Pain	□	□
Rash / Itching	□	□
Skin Peeling Hands/Feet	□	□
New Skin Growths/Sores	□	□
Easy to Bruise	□	□
Unusual Bleeding	□	□
General Weakness	□	□
Headaches	□	□
Numbness or Tingling	□	□
Anxiety	□	□
Depression	□	□
Seizures	□	□

If other condition, explain_____

Prior Cancer Treatment

Have you ever had chemotherapy? □ Yes □ No

If yes, list the type of chemotherapy given_____

If yes, dates of treatment_____ Date of last treatment_____

Name of facility_____

Have you ever had radiation therapy? □ Yes □ No

If yes, what area of your body was treated?_____

If yes, dates of treatment_____ Date of last treatment_____

Name of facility_____

Accessibility *(circle any that apply)* Wheelchair Walker Cane Oxygen None

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HEALTH HISTORY

Patient_____ **DOB**_____

Safety and Comfort	Yes	No
Do you live alone?	☐	☐
Are you on oxygen?	☐	☐
Do you have a history of falls or unsteady gait?	☐	☐
Do you have claustrophobia?	☐	☐
Do you need medication before CAT scans or MRI scans?	☐	☐
Do you have a pacemaker or implanted defibrillator?	☐	☐
Have you had a hip replacement?	☐	☐
Do you wear dentures?	☐	☐
Do you have scleroderma or Sjorgren's syndrome?	☐	☐
Do you have obstructive sleep apnea (OSA)?	☐	☐
Are you taking Metformin?	☐	☐
Do you have metal implants?	☐	☐

If yes, location of implants_____

WOMEN ONLY

Gynecologic History

Age cycle began_____ Usual Duration_____ days Regular ☐ Yes ☐ No

Pain or Cramps ☐ Yes ☐ No Heavy ☐ Medium ☐ Light ☐

Cycle Days from start to start_____ Date of last period_____

Duration of birth control use_____ Age at first mammogram_____

Date of last mammogram_____ Duration of hormone replacement therapy_____

Age at menopause_____ Are you sexually active? ☐ Yes ☐ No

Female problems/infections_____

Bra size (for breast cancer patients only)_____

Pregnancies

How many children born alive?_____ How many stillbirths?_____ How many prematures?_____

How many miscarriages?_____ How many Cesarean Sections?_____

Could you be pregnant? ☐ Yes ☐ No Age at first pregnancy_____

Did you breastfeed? ☐ Yes ☐ No If yes, how long?_____

Any complications with any pregnancy? ☐ Yes ☐ No

If yes, explain_____

MEN ONLY

Male History

Age at first PSA_____ Is your PSA checked regularly? ☐ Yes ☐ No

Have you had a TURP (roto-rooter)? ☐ Yes ☐ No What date was the surgery?_____

How many times do you urinate during the night?_____

Have you had prostate infections? ☐ Yes ☐ No If yes, when?_____

Do you take any of the following medication? (circle any that apply): Viagra Levitra Cialis Hytrin

Flomax Lupron Casodex Zoladex Flutamide Proscar Avodart Cardura