Mercy Clinic Oncology and Hematology – David C. Pratt Cancer Center
607 S. New Ballas Road, Suite 3300
St. Louis, MO 63141
Phone: 314-251-4400
Fax: 314-251-6375

Today's Date:_____

Mercy

Patient History

Name:_____ Date of Birth:_____

Why are you here today? (In your own words.)

_____

_____

Referring Physician: _____
Primary Physician: _____

Other Physicians seen in past year: _____

_____

Surgeries: (i.e. gallbladder, hernia, bypass, etc.)		
Surgery/Problem:	Hospital:	Year:
Surgery/Problem:	Hospital:	Year:
Surgery/Problem:	Hospital:	Year:
Surgery/Problem:	Hospital:	Year:
Other Hospital Admissions: (i.e. heart attack, stroke, etc.)		
Problem:	Hospital:	Year:
Problem:	Hospital:	Year:
Problem:	Hospital:	Year:
Problem:	Hospital:	Year:

Women Only

Number of Pregnancies:_____ Number of Children:_____

Menopause: Yes No (if yes, at what age? _____) Are you on medication? Yes No

Diabetes	YES	NO
Heart Failure	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO
Heart Attack or Angina	YES	NO
Stroke	YES	NO
Seizures	YES	NO

Depression	YES	NO
Hepatitis	YES	NO
Blood Clots	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Ulcers	YES	NO
Diverticulitis	YES	NO

Others (list):_____

List All Medications:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Allergies to Medication: (list all and type of reaction to each, i.e.: rash, difficulty breathing, nausea, etc.)

Medication:_____ Reaction: _____

Medication:_____ Reaction: _____

Medication:_____ Reaction: _____

Habits: (circle)

Alcohol: Everyday Occasional Never

Tobacco: Cigarettes (____packs per day) Pipe Cigars Chewing Tobacco

Social History: (circle)

Marital Status: Single Married Divorced Widow/Widower

Employment Status: Working Retired Unemployed Disabled

Job Type: (i.e. housewife, carpenter, factory, etc.)_____

Family History: (circle)

Relation	Living?	Age	Cancer?	Heart Disease?	Diabetes?
Father:	YES NO		YES NO	YES NO	YES NO
Mother:	YES NO		YES NO	YES NO	YES NO
Sisters:	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO
Brothers:	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO
	YES NO		YES NO	YES NO	YES NO

Review of Symptoms: (circle any symptoms that you may be experiencing)

GENERAL:	Fever	Night Sweats	Weight Loss	
SKIN:	Rashes	Color Changes	Sensitive to Light	
HEMATOPOIETIC:	Anemia	Bleeding	Bruising	Enlarged Lymph Nodes
CNS:	Headaches	Fainting	Paralysis	Dizziness
EYES:	Double Vision	Blurred Vision	Pain	Drainage
EARS:	Vertigo	Hearing Difficulty	Tinnitus	Drainage
NOSE & THROAT:	Nosebleeds	Sinus	Hoarseness	Bleeding Gums
BREASTS:	Masses	Tenderness	Drainage	
PULMONARY:	Short of Breath with minimal exertion		Wheezing	Coughing with Blood
CARDIOVASCULAR:	Chest Pain	Hypertension	Palpitations	Edema (swelling)
GASTROINTESTINAL:	Diarrhea	Nausea / Vomiting	Blood in stool	Jaundice
URINARY TRACT:	Urgency	Frequency	Blood	Pain
GENTIAL MALE:	Discharge	Masses		
GENTIAL FEMALE:	Discharge	Masses		
MUSCULOSKELETAL:	Pain	Arthritis		
ENDOCRINE:	Heat/Cold Intolerance	Increased thirst or eating	Nervousness	Hair Changes

MERCY CLINIC ONCOLOGY AND HEMATOLOGY

Patient Information Form

PLEASE PRINT CLEARLY. **ALL information must be completed; no section is to be left blank.**

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Address:	**Marital Status:** S M W D (Circle one)	
City:	**State:**	**Zip:**
Home Phone:	**Cell/Work Phone:**	
SS Number:		

EMPLOYER/SCHOOL INFORMATION	
Employer/School:	**Employed**: ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐ Not Employed
Referring Physician:	**Phone:**
Primary Care Physician:	**Phone:**
Emergency Contact:	**Relationship:**
Emergency Contact Phone:	☐ **Home** ☐ **Work** ☐ **Cell**

INSURANCE INFORMATION		
Primary Insurance:	**Id#:**	**Subscriber SSN:**
Subscriber:		**Subscriber DOB:**
Subscriber's Employer:		
Your relationship to Subscriber: ☐ Self-Employee Plan ☐ Self-Retiree Policy ☐ Husband ☐ Wife ☐ Child		
Secondary Insurance:	**Id#:**	**Subscriber SSN:**
Subscriber:		**Subscriber DOB:**
Subscriber's Employer:		
Your relationship to Subscriber: ☐ Self-Employee Plan ☐ Self-Retiree Policy ☐ Husband ☐ Wife ☐ Child		

Assignment of Insurance and Release Assignment

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records. I hereby assign all medical and other benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, etc., to Mercy Clinic Oncology and Hematology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that if my account is not paid when due, I will be responsible for all costs incurred in the collection process of my account. I further understand that my account may be reported to a credit bureau.

Unless specified otherwise by my insurance plan, I understand that payments for services are expected at the time of service.

PATIENT(S) OR AUTHORIZED PERSON(S) SIGNATURE: I authorize release of any medical information necessary to process any and all medical claims. I also authorize payment to be made for said claim(s) to insurance, etc. to Mercy Clinic Oncology and Hematology. I have read and understand and agree with all the information set forth in this document.

Signature of Patient/Responsible Party: _____ **Date:** _____

Mercy Clinic Oncology and Hematology does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the administrator of this practice. You will not suffer any penalty because you file a complaint.

Mercy

COMPREHENSIVE FAMILY HISTORY QUESTIONNAIRE

Do you have any relatives that have undergone genetic testing? YES* NO

*If yes, please obtain copies of the genetic testing results for each relative that has undergone the genetic testing. These results are necessary if you are to undergo testing.

What is your ethnicity? (Please circle one)

White African- American Hispanic Asian Other

Where are your ancestors from?

_____
(Examples: England, Germany, Russia, Middle East, Japan, Mexico, Central America, etc.)

My mother's ancestors are from:

_____

My father's ancestors are from:

_____

Are you of Ashkenazi Jewish ancestry? YES NO

Have you ever been diagnosed with cancer? YES NO

If yes: type of cancer: _____ Age at diagnosis:_____

Have you ever undergone a colonoscopy? YES NO

If yes: were any pre-cancerous (adenomatous) polyps found? YES NO

If yes: how many and at what age? _____

If female: age at menarche (when did your periods start)? _____

Do you have children? YES NO

If yes: how old were you when your first child was born? _____

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I, _____, have been informed that genetic testing requires **two appointments**. I have been informed that due to the in-depth discussion of my genetic testing results whether negative or positive I will only be given results during a face to face scheduled appointment.

I understand that if my insurance plan requires a co-payment I will be responsible for paying my co-pay at each visit.

_____ _____

Signature Date Witness Date

PATIENT COMMUNICATION FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Do we have your permission to:	Circle One			Phone Number
Leave a message on your **cellular phone**?	YES		NO	
Leave a message on your answering machine at **home**?	YES		NO	
Leave a message at your place of **employment**?	YES		NO	
Discuss your medical condition with other members of your family or friends?	YES		NO	

If YES, please list below the name(s) of the people and their relationship to you. Please list your spouse and/or other family or friends who may call our office. If you do not list anyone, Mercy Clinic **CANNOT discuss your medical information with anyone but you.

I, _____, give permission to Mercy Clinic to release information (verbal or written) about me, my medical condition and/or treatment to the following person(s):

NAME OF PERSON **RELATIONSHIP TO PATIENT** **TELEPHONE NUMBER**

_____

_____

_____

I understand that I may rescind this release at any time and will do so in writing.

I also acknowledge that I have been given the Mercy Clinic Privacy Notice.

X _____ _____

Patient's or Legal Guardian's Signature Date

Important Information to read before beginning the Mercy Genetic Testing Family Information Packet

If you have any relatives that have undergone genetic testing, you must obtain all copies of the genetic testing for each relative. This is especially important if they tested positive for a deleterious mutation. These results are necessary if you are to undergo testing.

The Mercy Genetic Testing Family form must be **COMPLETED IN ITS ENTIRETY**. If you do not know the age or reason of death, please try to obtain a copy of the relative's death certificate or any other information that would assist in completing the form. If you cannot obtain that information, please indicate on the form.

If you **do not have any** aunts, uncles, cousins, siblings, nieces, nephews or children, **please indicate in each section of the form.**

Myriad is the company that completes the testing process. Myriad will contact your Medical Insurance Company to determine the amount that will be paid by insurance and the amount that will be the patient's responsibility. If the **patient is responsible for MORE than $375**, **Myriad will not process the specimen without contacting you**. If the **patient responsibility is LESS than $375 the specimen will be processed without contacting you.**