

Welcome to Oncology San Antonio. We pride ourselves on offering comprehensive, individualized medical care for patients with cancer and with blood disorders. We also are one of the few groups in San Antonio providing integrative oncology and a comprehensive breast program.

We welcome patients referred by their medical care provider or patients who refer themselves and it is an honor and privilege to have been selected to work with you.

We will create a plan of care that is individualized to your needs. We will go to great lengths to help you understand your condition and the available clinical research so that you can make an informed decision regarding your treatment plan.

Our goal is to make your experience as pleasant, relaxing, and informative as possible. Please complete the enclosed New Patient Packet, and return it to us during your first visit. You will also need the following documents to ensure your registration goes smoothly:

- Drivers license or official photo ID
- Current insurance card
- List of current medications, to include all prescribed medications, recreational medications, vitamins, and supplements
- List of all providers and specialists who provide care to you
- Completed new patient packet (enclosed)
- Previous medical records (if requested)

Please remember that your appointment time is valuable. If you are unable to make your appointment, please let us know at least 24 hours ahead of time so that we may schedule someone else that needs care.

Please plan to arrive 30 minutes prior to your appointment time to complete your registration and meet our front office team.

Should you have any questions, please do not hesitate to call 210.544.5111. We look forward to meeting you.

Bertha Leal
New Patient Coordinator
South Texas Radiation Oncology Partners
Oncology San Antonio Cancer Care Network



Oncology San Antonio Cancer Care Network Locations

www.oncologysa.com

DOWNTOWN
215 East Quincy St., Ste. B100
San Antonio, Texas 78215
Office: 210.299.8000
Fax: 210.299.8099

LIVE OAK
12705 Toepperwein Road
San Antonio, Texas 78233
Office: 210.599.0922
Fax: 210.599.2951

MEDICAL CENTER
9102 Floyd Curl Drive
San Antonio, Texas 78240
Office: 210.616.9922
Fax: 210.616.9901

STONE OAK
19288 Stone Oak Pkwy., Ste. B
San Antonio, Texas 78258
Office: 210.490.2707
Fax: 210.490.2986

MISSION TRAIL
8019 South New Braunfels Ave., Ste. 101
San Antonio, Texas 78235
Office: 210.922.5556
Fax: 210.922.5557

Consent for EMR (Electronic Medical Record) Photography

Oncology San Antonio uses Electronic Medical Records (EMR) to maintain your health care information. The beneficial capabilities of the EMR allow us to use a digital photo to visually identify our patient while reviewing a chart. *Oncology San Antonio* will only use your picture for identification purposes. Your picture will not be included with any medical record releases or shown to anyone other than *Oncology San Antonio* staff for identification purposes. *Oncology San Antonio* is committed to maintaining the privacy and confidentiality of your health information, as defined in our Notice of Privacy Practices that complies with HIPPA.

You may, at any time, withdraw this consent with a written notice.

PLEASE CHECK ONE:

YES. I agree to have my photo taken. I, _____, understand that by checking this box and signing this form, I am giving *Oncology San Antonio* permission to take a photo of me to use solely for identification purposes in the EMR. I understand the terms of the usage of my photo.

NO. I wish not to have my photo taken and used for EMR identification purposes.

Signature of Patient: _____ **Date** ____ / ____ / _____

Consent for Email and/or Text Message Communication

Oncology San Antonio may be contacting you via email, text messaging and/or our patient portal to remind you of upcoming appointments, to obtain feedback, and to provide you with lab results.

With your signature below, you consent to receiving appointment reminders and other healthcare communications/information at that email address and/or mobile device from *Oncology San Antonio*.

_____ (Patient initials) I consent to receive text messages from *Oncology San Antonio* at my mobile phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders is
(_____) _____ - _____

_____ (Patient initials) I consent to receive emails from *Oncology San Antonio* to receive communications about lab results, testimonial requests and general health reminders/information. The email that I authorize to receive email messages at is
_____ @ _____

Signature of Patient: _____ **Date** ____ / ____ / _____

Patient's Bill of Rights

You have the right to considerate and respectful care.

You have the right to the most appropriate medical treatment available regardless of sex, race, religion, color, or national origin.

You have the right to obtain from your provider complete, current information concerning your diagnosis, treatment and possible outcome in understandable terms. When it is not medically advisable to give such information to you, the information will be made available to an appropriate person on your behalf.

You have the right to discuss with your provider any treatment, procedure, or operation planned for you so that you may understand the purpose, probable results, alternatives and risks involved before giving permission.

You have the right to refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of your refusal.

You have the right to leave the office and facility, against your provider's advice, to the extent permitted by law and government regulations. If you leave the office or facility against your provider's advice, neither the facility, neither your provider, nor the United States Government will be responsible for any harm that this action might cause you or others.

You have the right to privacy concerning your medical care program in accordance with the law and regulations.

You have the right to a reasonable response to your request for service.

You have the right to obtain information as to any relationship of your facility to other health care and educational institutions in so far as your care is concerned. You have the right to obtain the name, position, and professional relationships of all individuals who are treating you.

You have the right to see another provider.

You have the right to be advised if the facility proposes to engage in or perform research associated with your care or treatment. You have the right to refuse to participate in such research projects.

You have the right to know which facility rules and regulations apply to your conduct as a patient.

If you have any questions or concerns regarding this form, please call 210.544.5111 or e-mail newpatient@oncologysa.com.

Patient's Responsibilities

The Statement of Patient's Responsibilities, designed as a companion to the Patient's Bill of Rights, encourages patients to participate in their own health care and treatment. *Oncology San Antonio* believes that a mutual understanding of the Patient's Bill of Rights and Responsibilities will result in more effective delivery of health care services. To the extent possible, *Oncology San Antonio* requests that patients:

- Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and answer any questions concerning these matters.
- Participate in your health care planning by talking openly and honestly about your concerns with your provider and other health care professionals.
- Understand your diagnosis and treatment to your satisfaction and ask questions if you do not understand your treatment plan.
- Cooperate with your provider and other health care professionals in carrying out your treatment plan.
- Participate and cooperate with our health care professionals in creating a discharge plan, which meets your medical and social needs.
- Inform *Oncology San Antonio* or any of its professionals of the existence of any advance directive (including health care proxy, power of attorney, DNR, living will) you may have created.
- Provide information relating to insurance and other sources of payment.
- Cooperate and abide by *Oncology San Antonio* rules, regulations and policies.
- We also ask that you be considerate of your fellow patients, respecting their need for privacy and a quiet environment, as we expect them to do for you as well.

If you have any questions or concerns regarding this form, please call 210.544.5111 or e-mail newpatient@oncologysa.com.

Assignment of Benefits

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER
LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE
AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND
DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to *Oncology San Antonio*, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by *Oncology San Antonio*, regardless of its managed care network participation status.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

I hereby authorize *Oncology San Antonio* to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to *Oncology San Antonio* any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from *Oncology San Antonio* or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to *Oncology San Antonio* any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from *Oncology San Antonio* (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to *Oncology San Antonio* all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by *Oncology San Antonio*, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims).

The assignee and/or designated representative (*Oncology San Antonio*) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator.

Oncology San Antonio and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature of Patient or Guardian:

Date:

____ / ____ / _____

Authorization to Release Medical Records

I, _____ (patient's full name), authorize *Oncology San Antonio* to release confidential health information about me to the individual(s) listed below:

1. Full Name: _____
 Relationship to Patient: _____ DOB: ____ / ____ / ____
 Phone Number: (____) ____ - _____ Email (Optional): _____

2. Full Name: _____
 Relationship to Patient: _____ DOB: ____ / ____ / ____
 Phone Number: (____) ____ - _____ Email (Optional): _____

3. Full Name: _____
 Relationship to Patient: _____ DOB: ____ / ____ / ____
 Phone Number: (____) ____ - _____ Email (Optional): _____

4. Full Name: _____
 Relationship to Patient: _____ DOB: ____ / ____ / ____
 Phone Number: (____) ____ - _____ Email (Optional): _____

I understand that the information released can include some or all of the following: a copy of my medical records, a summary or narrative of my protected health information, or a verbal conversation.

Note: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore is no longer protected by the Health Insurance Portability and Accountability Act (HIPPA) or other federal or state laws. This authorization will last in perpetuity unless you specify otherwise:

Special Notes or Requests by patient:

Full Legal Name of Patient (Please Print): _____ **Patient Date of Birth:** ____ / ____ / ____ **Patient SSN:** ____ - ____ - ____

Signature of Patient or Guardian: _____ **Date:** ____ / ____ / ____

Medical Records Release Authorization

Patient name: _____ Date of Birth: ____ / ____ / ____

Address: _____

Phone Number: (____) ____ - ____ Treatment dates from: ____ / ____ / ____ to ____ / ____ / ____

I authorize: (enter your current provider's information)

Provider name: _____

Address: _____

Phone Number: (____) ____ - ____

Fax Number: (____) ____ - ____

To release copies of my medical records to: (select provider)

- | | | |
|---|---|---|
| <input type="checkbox"/> Basel Dabas, MD | <input type="checkbox"/> Zulfi Jaffar, MD | <input type="checkbox"/> Navneet Mittal, MD |
| <input type="checkbox"/> Jayasree Rao, MD | <input type="checkbox"/> Syed Raza, MD | <input type="checkbox"/> Kimberly Stewart, DO |
| <input type="checkbox"/> Angelia Berkowitz, DNP, APRN, FNP, AOCNP | | |
| <input type="checkbox"/> Rachel Balli, MSN, APRN, ACNP-BC | <input type="checkbox"/> Reylin Segura, MSN, APRN, FNP-BC | |

I understand that this information shall be in effect for one year following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the released copies.

I hereby release *Oncology San Antonio* from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Signature of Patient or Guardian:

Date:

____ / ____ / ____

Patient Demographic Form

Patient Data:

Title: (Check one) Mr. Mrs. Ms. Miss Dr.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Nickname: _____ **Date of Birth:** _____ / _____ / _____ **Sex:** Male Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____ **Email:** _____

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Student Retired Other (check one)

Race: Native American/American Indian Asian Black/African American Pacific Islander White

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown Do not want to disclose

Referring Provider Info:

Referring Provider: _____ **Phone:** (_____) _____ - _____

Primary Care Provider: _____ **Phone:** (_____) _____ - _____

Surgeon: _____ **Phone:** (_____) _____ - _____

Other Specialist: _____ **Phone:** (_____) _____ - _____

Pharmacy Info:

Pharmacy Name: _____ **Phone:** (_____) _____ - _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact:

Name: _____ **Phone:** (_____) _____ - _____

Relationship: _____

Name: _____ **Phone:** (_____) _____ - _____

Relationship: _____

Billing Information

Insurance Information:

Primary Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____ - ____ - ____ **DOB:** ____ / ____ / ____
(Name as it appears on the card) (Policy Holder) (Policy Holder)
Employer Associated with Policy: _____

Secondary Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____ - ____ - ____ **DOB:** ____ / ____ / ____
(Name as it appears on the card) (Policy Holder) (Policy Holder)
Employer Associated with Policy: _____

Additional Insurance: _____
Policy Number: _____ **Group Number:** _____
Policy Holder: _____ **SSN:** ____ - ____ - ____ **DOB:** ____ / ____ / ____
(Name as it appears on the card) (Policy Holder) (Policy Holder)
Employer Associated with Policy: _____

1. Are you currently staying in a Skilled Nursing Facility (SNF) or convalescent home?

Check One: YES NO If YES:

Facility Name: _____ **Phone:** (____) _____ - _____

2. Are you currently on hospice?

Check One: YES NO If YES:

What is your diagnosis? _____

3. Do you have a home health provider?

Check One: YES NO If YES:

Provider Name: _____ **Phone:** (____) _____ - _____

Full Legal Name of Patient (Please Print):

Signature of Patient or Guardian:

Date:

____ / ____ / ____

History and Physical

Date: ____ / ____ / _____ Referring Provider: _____ Age: _____

Insurance: _____

Diagnosis:	Date of diagnosis: ____ / ____ / _____
History of present illness: (to be filled out by staff)	

Which provider(s) are involved with your care? **Please write in the name of each provider:**

Primary care/Internist: _____

Surgeon: _____

OB/GYN: _____

Other: _____

For Head and Neck Cancer Patients Only: Dentist: _____

Phone Number: _____ Date of last exam?: ____ / ____ / _____

Have you had any scans, x-rays or other tests related to your diagnosis?

Test	Yes	No	Performed where?	Date
CT Scan				
MRI Scan				
Bone Scan				
Ultrasound				
Pet Scan				
BMD				
C-Scope				
Biopsy				
EGD				
Other				

Current Type of Treatment?

Test	Yes	No	What hospital?	Date
Surgery				
Radiation				
Drug TX/Chemo				
Hormone Therapy				

History and Physical (continued)

Female History:

1. Do you have regular mammograms?

Check One: YES NO If YES:

Where? _____ Last Exam: ____ / ____ / _____

2. Do you have regular PAP tests?

Check One: YES NO If YES:

Where? _____ Last Exam: ____ / ____ / _____

3. Do you examine your own breasts?

Check One: YES NO _____ Last Exam: ____ / ____ / _____

4. Age that you started menstruation? _____ Age: _____

5. Have you had a hysterectomy?

Check One: YES NO If YES:

Were your ovaries removed? **Check One:** YES NO

6. Age at menopause? _____ Age: _____

7. Date of last menstrual period: _____ Date: ____ / ____ / _____

8. Have you ever used oral contraceptives?

Check One: YES NO If YES: How long? _____ Years

9. Do/did you use hormone replacement therapy?

Check One: YES NO If YES: How long? _____ Years

10. Total # of pregnancies: _____ Total # of live births: _____ Total # of miscarriages: _____

11. Did you breastfeed?

Check One: YES NO If YES: How long? _____ Months

Male History:

1. Do you have regular prostate exams?

Check One: YES NO If YES:

Where? _____ Last Exam: ____ / ____ / _____

2. Do you have regular PSA tests?

Check One: YES NO If YES:

Where? _____ Last Exam: ____ / ____ / _____

3. Do you examine your own testicles?

Check One: YES NO _____ Last Exam: ____ / ____ / _____

History and Physical (continued)

Past Medical History:

Have you had any other cancers in the past?

Check One: YES NO If YES, list below:

Date Diagnosed	Treatment Received	Type of Cancer
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had radiation before?

Check One: YES NO If YES:

Where? _____ Date: ____ / ____ / ____

What type? _____

Have you had chemotherapy before?

Check One: YES NO If YES:

Where? _____ Date: ____ / ____ / ____

What type? _____

Do you have an Internal Electronic Device, i.e. defibrillator, pacemaker? YES NO

Past Medical History:

Have you ever been diagnosed with any of the following medical conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> DVT (blood clots) |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Known Genetic Defects:
_____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> GERD (Reflux) | |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Pulmonary Embolism | |

Other(s) _____

Past Surgical History:

Have you had any other procedures or operations?

- | | | |
|---|--|---|
| <input type="checkbox"/> Open heart surgery | <input type="checkbox"/> Colon resection | <input type="checkbox"/> Breast surgery |
| <input type="checkbox"/> Cardiac stent | <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Removal of kidney |
| <input type="checkbox"/> Parathyroid | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Organ transplant
(Type): _____ |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Hernia | <input type="checkbox"/> Joint replacement
(Type): _____ |
| <input type="checkbox"/> Hiatal hernia/reflux | <input type="checkbox"/> Hysterectomy | |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> C-section | |
| <input type="checkbox"/> Stomach resection | <input type="checkbox"/> Mastectomy | |

Other(s) _____

History and Physical (continued)

Family History:

Do/did you have any family members who are/were diagnosed with cancer or a blood disease?

FAMILY MEMBER (please specify)	TYPE OF CANCER/BLOOD DISEASE	AGE AT DIAGNOSIS

Social History:

1. What is / was your occupation? _____ Retired YES NO
2. With whom do you live? _____ Live alone YES NO
3. Do you have children? YES NO Ages: _____
4. Have you ever smoked?
Check One: YES NO If **YES:** # _____ packs per day for # _____ years
 If you used to smoke, when did you stop? ____ / ____ / _____
5. Do you drink alcohol?
Check One: YES NO If **YES:** Beer Wine Spirits # of drinks per week: _____
 If you used to drink, when did you stop? ____ / ____ / _____
6. Have you ever used recreational drugs? (Marijuana, cocaine, etc.)
Check One: YES NO If **YES:** Which drugs? _____
7. **Allergies:** (including medication, food, latex, peanuts, etc.)
Check One: YES NO If **YES:** Describe allergy and reaction below:

ALLERGY TO	REACTION

List all medications that you are currently taking, including over the counter medications, supplements and vitamins. (Skip to next question if providing separate medication list.)

MEDICATION	DOSAGE	FREQUENCY

Review of Systems

Please check all that apply:

GENERAL:

- Chills
- Sweats
- Weight Gain
- Weight Loss (last 6 months) –
How many pounds _____
- Fatigue
- Weakness
- Fevers
- Hot Flashes

HEENT (EYES, EARS, NOSE AND THROAT):

- Blurred Vision
- Double Vision
- Loss of Hearing
- Nose Bleeds
- Hoarseness
- Ringing in Ears
- Bleeding Gums
- Difficulty Swallowing

RESPIRATORY:

- Cough
- Shortness of breath:
On rest ___ on exertion _____
- Home oxygen: liters/min

- Sputum or phlegm
- Blood in sputum or phlegm

CARDIOVASCULAR:

- Chest Pain
- Irregular Heart Beat
- Palpitations
- Ankle Swelling

ENDOCRINE/

- METABOLIC:**
- Heat or cold intolerance
 - Poor control diabetes

HEMATOLOGICAL/

- LYMPHATIC:**
- Easy bruising
 - Bleeding

SKIN:

- Rash
- Moles
- Sores
- Lumps
- Healing incisions

**PSYCHOSOCIAL/
BEHAVIORAL:**

- Depression
- Anxiety
- Sleep problems

BREAST:

- Breast Lump
- Breast Pain
- Nipple Discharge

WOMEN ONLY:

- Vaginal discharge
- Abnormal vaginal bleeding
- Painful intercourse

GASTROINTESTINAL:

- Loss of Appetite
- Vomiting
- Diarrhea
- Rectal Bleeding
- Nausea
- Abdominal Pain
- Constipation
- Black Stools

GENITOURINARY:

- Urine Discoloration
- Blood in urine
- Burning urination
- Painful urination
- Frequent urination
- Lack of bladder control

MUSCULOSKELETAL:

- Pain Swelling

NEUROLOGICAL:

- Headache
- Seizure Memory Loss
- Dizziness Tremors
- Balance Problems
- Weakness
Location: _____
- Numbness
Location: _____
- Tingling
Location: _____

MEN ONLY:

- Erectile Dysfunction
- Lump in Testicles
- Penile Discharge
- Breast Pain
- Testicular Pain
- Swelling
- Lump

PAIN:

- Location: _____

How severe is your pain?

- 0: Absent (No pain)
- 1–2: Tolerable
(tolerate w/o medications)
- 3–4: Bearable
(some activities restricted/
prevented, requires medication)
- 5–6: Nearly intolerable
(sedentary, only able to watch
TV, read, etc.)
- 7–8: Intolerable
(can't read, watch TV, use phone,
need to visit ER for pain killers)
- 9–10: Devastating
(need hospitalization for pain
control)

Review of Systems (continued)

Please complete all that apply:

GYNECOLOGIC:

1. Age of first period: _____
2. Age of menopause: _____
3. Number of pregnancies: _____
4. Number of births: _____
5. Use of oral contraceptives? Yes or No: _____
 - a. How long?: _____
 - b. When stopped?: _____
6. Use of hormones? Yes or No: _____
 - a. How long?: _____
 - b. When stopped?: _____

Any history of auto-immune disease?

Lupus: _____
Scleroderma: _____
Rheumatoid arthritis (active): _____
Connective tissue disorder: _____
Multiple sclerosis: _____
Type 1 Diabetes: _____
Thyroid issues: _____

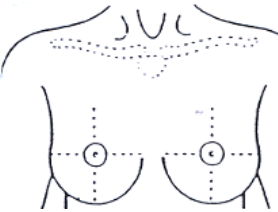
Last dental visit: _____

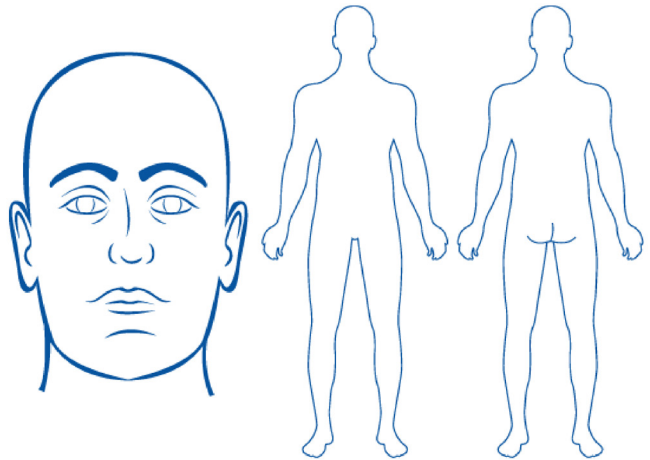
Dentist name: _____
Dentist phone number: _____

Physical Exam

This section will be completed by the nurse or provider.

Activity Level _____ Mode: Ambulatory _____ Wheel Chair _____ Stretcher _____
 Ht. _____ (ft. and in.) Wt. _____ (lb.) B/P _____ P _____ R _____ T _____ O2 Stats _____ %

GENERAL	
HEENT	
NECK	
LUNGS	
CARDIAC	
BREAST	
ABDOMEN	
EXTREMITIES	
MUSCULOSKELETAL	
GENITALS	
NEUROLOGICAL	
LYMPHATIC	



ASSESSMENT	PLAN
------------	------

Signature of Provider:

Date:
 ____ / ____ / ____