WEST CANCER CENTER & RESEARCH INSTITUTE

## Patient Information

## West Cosmetic & Reconstructive Surgery

General Patient Information:

Patient Name: _____ Date of Birth: _____

SSN: _____ Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____County:_____

Spouse (Next of Kin): _____ Relationship:_____ Phone: _____

Employer: _____ Work Phone: _____

**The below information will be used to contact you.** Please only provide information for any method you prefer West Cancer Center use for contact (e.g., work phone, mobile phone).

Email Address:_____ Home Phone:_____

Work Phone:_____ Mobile Phone (voice and text): _____

Contact Preference: Home / Work / Mobile/ Email Weight: _____ Height: _____

Insurance Information:

Primary Pharmacy:_____ Phone: _____

Pharmacy Cross Streets or Address: _____

Primary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Policy Holder DOB:_____

**Please provide a copy of your insurance card upon arrival.*

Information Required by Federal Government:

Race: ☐ Caucasian/White ☐ African American/Black ☐ American Indian ☐ Asian

☐ Other _____

Ethnic Background: ☐ Hispanic ☐ Non-Hispanic

Preferred Language:_____

How did you hear about us? ☐ Physician ☐ Family/Friend ☐ Internet Search ☐ Social Media ☐ Other

If physician, may we thank them for their referral?

Name:_____

Do you need language translation assistance? ☐ Yes ☐ No

Do you need interpreter aids or assistance? ☐ Vision ☐ Hearing ☐ Other

Do you require a physical accommodation? ☐ Yes ☐ No

If Yes, please let us know what type of accommodation is required. _____

Advanced Directive for Medical Care (Living Will):

Do you have a Living Will? ☐ Yes ☐ No

I acknowledge that if I have a Living Will or any form of Advanced Directives, I should inform West Cancer Center and present a copy even if one is created after my initiation of care.

Gender Information:

*For Clinical Use Only (please answer if applicable).*

What sex were you assigned at birth or what is your legal sex?

☐ Female ☐ Male

What is your current gender identity?

☐ Female ☐ Male ☐ Trans female to male ☐ Trans male to female ☐ Questioning/Unsure

☐ Decline to state ☐ Other _____

## Patient Representative Identification

By law, the HIPAA Privacy Rule Prohibits West Cancer Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. Persons involved in your care or payment for care, such as a family member or caretaker may have access to your health information related to their involvement unless you indicate otherwise. In addition, your legal representative may access or receive your health information on your behalf.

**Please list ALL PERSONS you wish to have access to your Protected Health Information (PHI): (i.e. those making appointments or checking on test results)**

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

**Can we discuss your bill with the above individuals?** ☐ Yes ☐ No

If no, list individuals below whom we can discuss your bill.

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

**Please list your Emergency Contact**:

Name:_____ Phone:_____ Relationship: _____

**NOTE: In an Emergency, HIPAA permits release of PHI as necessary for informing your Emergency Contact of your location and condition.**

**If applicable, please list your Legal Representative**:

Name:_____ Phone:_____ Relationship: _____

By what authority is this person your Legal Representative? (Please check one)

☐ Next of Kin ☐ Guardian ☐ General Power of Attorney ☐ Health Care Power of Attorney

**PLEASE NOTE:** In order for us to disclose your Private Health Information, the above representatives must be able to provide up to two (2) patient identifiers and documentation of legal representation.

Patient/Patient Representative Signature: _____

Date: _____

# Clinical History

Reason for your visit? _____

Is this due to an accident? ☐ Yes ☐ No If yes specify: _____

Is the accident job relate? ☐ Yes ☐ No If If yes date: _____

Past/Present Illness:

| | Yes | How long? | | Yes | How long? |
|---|---|---|---|---|---|
| **Heart and Blood Vessels** | | | **Skin** | | |
| Anemia | | | Psoriasis | | |
| Angina | | | Skin Condition(s) | | |
| Blood Clot | | | **Kidney/Bladder** | | |
| Chest Pain | | | Kidney Disease | | |
| Deep Vein Thrombosis (DVT) | | | Kidney Stones | | |
| Heart Attack | | | Urinary Tract Infection | | |
| Heart Disease/Failure | | | **Blood Disorders** | | |
| High or Low Blood Pressure | | | Bleeding with tooth | | |
| Irregular Heartbeat | | | Blood Clots/Clotting | | |
| Peripheral Vascular Disease | | | Easy bruising | | |
| Rheumatic Fever | | | **Immune System** | | |
| Stent Placement | | | Other Collagen Vascular | | |
| Stroke/TIA | | | Human Immune Virus | | |
| **Brain and Nerves** | | | Lupus | | |
| Glaucoma | | | **Joint/Skelton** | | |
| Migraines | | | Arthritis | | |
| Multiple Sclerosis | | | Rheumatoid Arthritis | | |
| Parkinson's Disease | | | **Endocrine** | | |
| Seizures or Epilepsy | | | Diabetes or Sugar | | |
| **Lungs** | | | Thyroid Disease or | | |
| Allergies | | | **Psychological** | | |
| Asthma | | | Anxiety | | |
| Chronic Bronchitis | | | Depression | | |
| Emphysema/COPD | | | Psychiatric Treatment | | |
| Pneumonia | | | **Other** | | |
| Pulmonary Embolism | | | Birth Defects / Birth | | |
| Sleep Apnea | | | GYN Problems | | |
| Tuberculosis (TB) | | | Hepatitis/Liver Disease | | |
| **Stomach/Intestines** | | | HIV | | |
| Colitis | | | Jaundice | | |
| Crohn's Disease | | | Sinusitis | | |
| Diverticular Disease | | | Vision Problems | | |
| Gall Bladder Disease | | | Other: | | |
| Kidney / Bladder Trouble | | | Other: | | |
| Pancreatitis | | | Other: | | |
| Recent Weight Loss / Gain | | | Other: | | |
| Ulcers of Stomach or | | | Other: | | |

Personal Cancer History:

Have you been treated for cancer? □ Yes □ No

| Caner Type | | Yes/No | Date Treated | Treating Physician | Where? |
|---|---|---|---|---|---|
| | Did you receive chemotherapy? | | | | |
| | Did you have surgery? | | | | |
| | Did you have radiation? | | | | |

Past Surgeries/Significant Medical Events

None: (please check box if none) □

| **Surgery/Event Type** | **Date** | **Hospital Performed** | **Surgeon Name** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you under the care of a cardiologist? □ Yes □ No Doctor Name: _

Do you have any surgical hardware (please check yes for all that apply)?

□ Hip Valve(s) □ Pacemaker □ Defibrillator □ Aneurysm Clip

□ Mechanical Stimulating Device (Neuro Stimulator, Infusion Pump, etc) □ Other _____

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when? _____ Where? _____

Have you ever had a mammogram? ☐ Yes ☐ No If yes, when? _____ Where? _____

Have you ever had polyps? ☐ Yes ☐ No If yes, when? _____

Have you ever had local anesthesia for dental work or a minor surgery? ☐ Yes ☐ No

If yes, did you have a reaction?_____

Please list any other physicians you currently see:

| Physician Name | Specialty |
| --- | --- |
| | |
| | |
| | |

Allergies and Reactions:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to contrast IV? ☐ Yes ☐ No

Have you had any vaccinations? ☐ Yes ☐ No

If yes, which?_____

Have you ever had local anesthesia for dental work or a minor surgery? ☐ Yes ☐ No

If yes, did you have a reaction?_____

List any allergies and reactions:

| Allergy | Type of Reaction |
| --- | --- |
| | |
| | |
| | |

Social History:

Do you or did you ever smoke? ☐ Current ☐ Former ☐ Never

If current, estimate how many packs a day:_____ If former, how many years?_____

Do you vape? ☐ Current ☐ Former ☐ Never

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you have a history of recreational drug use? ☐ Yes ☐ No If yes, what type? _____

Family Medical History

Patient Name:_____

Do you have any relatives with cancer? □Yes □No

| Family Member | Chronic Disease or Conditions | Cancer Site (ex. breast, colon) | Age Detected | Living (L) or Deceased (D) | Current Age or Age at Death |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Children | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Family Member | Maternal | Paternal | Chronic Disease or Conditions | Cancer Site | Age Detected | Living (L) or Deceased (D) | Current Age or Age at Death |
|---|---|---|---|---|---|---|---|
| Grandfathers | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Grandmothers | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Aunts | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Uncles | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| First Cousins | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Medications

**Patient Name:_**

**Date of Birth:__**

Please list all medications, including vitamins, herbals, or other over-the-counter medications

| Name of Medicine | Dose (strength/ milligrams) | Frequency (How often do you take this medicine) | Why do you take this medicine? | Start Date (When did you start taking this medicine?) | Do you have any problems with this medicine? Yes or No |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

WEST
CANCER CENTER
& RESEARCH INSTITUTE

## Patient Privacy Notice Acknowledgement:

I acknowledge that **West Cancer Center's Notice of Privacy Practices** has been made available to me.

*This packet is available on the West Cancer Center website, westcancercenter.org,*

*and available for print at all front desk locations by request.*

Patient or Patient Representative Signature:_____

Date: _____