GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____________________________________ ________________
Signature of Patient or Personal Representative — Date

____
Printed Name of Patient or Personal Representative

____
Relationship to Patient

____________________________________ ________________
Signature of Witness — Date

____
Printed Name of Witness

Place Label Here

Patient Name: ______________________________ **DOB:**____________________

PATIENT MEDICAL HISTORY FORM - FOR OB PATIENTS ONLY

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: ____

DOB: ____/____/____ **Age:** __________ ❑ **Male** ❑ **Female** **SS#:** ______________________

Primary Address: ____

City: ______________________________ State:__________ Zip: __________

Home Phone: ❑ Preferred (______) ______________________________

Cell Phone: ❑ Preferred (______) ______________________________

Secondary Address: ____

City: ______________________________ State: __________ Zip: __________

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: ______________________________ May we email you? ❑ Yes ❑ No

Preferred Language: ______________________

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: ____

Pharmacy Phone # and Cross Streets:____

(Internal Use Only)

MRN#: ______________

Patient Name: ______________________________ **DOB:** ____________

Primary Care Physician: ______________________________ Phone: ____________

Referring Physician (if different): ______________________________ Phone: ____________

Please list any additional Physicians you see: (Include Phone #):

______________________________ Phone: ____________

______________________________ Phone: ____________

______________________________ Phone: ____________

______________________________ Phone: ____________

Emergency Contact Name:

____

Relationship: ______________________________ Phone: (______) ____________

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):______________________________

Name of Employer: ______________________________ Work Phone: (______) ____________

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

Patient Name: ______________________________ **DOB:** ______________

Medical History Have you EVER had any of the following:

❑ Asthma
❑ Psychiatric Disorder/Illness
❑ Cancer
❑ Seizures or Epilepsy
❑ Diabetes
❑ Urinary/Kidney Disorder
❑ Neurological Disorder/Chronic Headaches
❑ Blood Pressure Disorder/Hypertension
❑ Stroke
❑ COPD
❑ Thyroid Disorder
❑ Heart Attack/Heart Disease/Atrial Fib
❑ Arthritis
❑ Pulmonary Embolism/DVT/Blood Clots
❑ Cholesterol Disorder/Hyperlipidemia
❑ Sleep Apnea
❑ Eye Disorder (i.e. Glaucoma)
❑ Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

____

____

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? ❑ Yes ❑ No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Allergies

Are you allergic to any medications or other substances? ❑ Yes ❑ No Please list allergies and reactions:

____

____

Patient Name: ____ **DOB:** ______________

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? ❑ Yes ❑ No If yes, please use the back of this page to list all others.

Health Maintenance

Date of last bone density: ____________________

Date of last pap smear: ______________________ Have you ever had an abnormal PAP smear? ❑ Yes ❑ No

If yes, did you receive any treatment? ❑ Yes ❑ No

Date of last mammogram: ___________________ Was that mammogram normal? ❑ Yes ❑ No

Date of last colonoscopy: ____________________ Was that colonoscopy normal? ❑ Yes ❑ No

Family Medical History Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Social History

Do you currently smoke? ❑ Yes ❑ No If no, previously? ❑ Yes ❑ No
Years smoked______ Packs per day _______

Do you use other tobacco products? ❑ Yes ❑ No Consume Alcohol? ❑ Yes ❑ No If yes, drinks per week: ______

Do you do any drugs (including marijuana)? If yes, what drug and for how long? ___________________________

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Do you suffer from domestic violence? ❑ Yes ❑ No Do you feel safe at home? ❑ Yes ❑ No

Patient Name: ____ **DOB:** ____________

Pregnancy History

Number of pregnancies: _______ Number of C-Section deliveries: ______ Number of abortions: ______

Number of miscarriages: _______ Number of vaginal deliveries: ________

GYN History

Age of first period: ____________________ Do you have monthly periods? ❑ Yes ❑ No

Are your periods regular? ❑ Yes ❑ No How often? How many days? ______________________________

Date of last menstrual period: _____________

Have you received an HPV vaccine series? ❑ Yes ❑ No If yes, when? ______________________________

Have you had any genetic testing? ❑ Yes ❑ No If yes, when? _________________________________

Are you taking or have you taken hormone replacement therapy? ❑ Yes ❑ No

Age at menopause: __________

Sexual History:

Do you have a partner? ❑ Yes ❑ No ❑ Male ❑ Female

Patient Name: ____ **DOB:** ______________

Review of Systems Please indicate ALL that you have experienced within the last 6-12 months.

General

- ❑ None
- ❑ Feeling Tired
- ❑ Fever
- ❑ Weight Gain
- ❑ Chills
- ❑ Weight Loss
- ❑ Feeling Poorly

Eyes

- ❑ None
- ❑ Dry Eyes
- ❑ Eye Pain
- ❑ Itchy Eyes
- ❑ Vision Changes
- ❑ Eyesight Problems

Ear/Nose/Throat

- ❑ None
- ❑ Earache
- ❑ Loss of Hearing
- ❑ Nose Bleeds
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Hoarseness

Heart

- ❑ None
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Slow Heart Rate
- ❑ Leg Swelling
- ❑ Fast heart rate
- ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

- ❑ None
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Trouble breathing with exertion
- ❑ Trouble breathing when lying flat

Gastrointestinal

- ❑ None
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Blood in stool

Skin

- ❑ None
- ❑ Acne
- ❑ Itching
- ❑ Change in mole
- ❑ Skin Lesions
- ❑ Skin Wound
- ❑ Breast Lump

Neurological

- ❑ None
- ❑ Limb Weakness
- ❑ Confused
- ❑ Loss of Memory
- ❑ Convulsions
- ❑ Headaches
- ❑ Dizziness
- ❑ Difficulty Walking

Psychiatric

- ❑ None
- ❑ Suicidal
- ❑ Anxiety
- ❑ Disturbed Sleep
- ❑ Depression
- ❑ Emotional Problems
- ❑ Change in Personality

Endocrine

- ❑ None
- ❑ Hair Loss
- ❑ Weak Muscles
- ❑ Hot Flashes
- ❑ Feeling Weak
- ❑ Deepening Voice

Hem/Lymph

- ❑ None
- ❑ Easy Bleeding
- ❑ Easy Bruising
- ❑ Swollen Glands

Patient Name: ____ **DOB:**____________________________

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

______ **I give permission to the employees of Cancer & Blood Specialists of Arizona (CBSA/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):**

Name: ____ Relation: ______________ Phone:____________

Name: ____ Relation: ______________ Phone:____________

Name: ____ Relation: ______________ Phone:____________

Name: ____ Relation: ______________ Phone:____________

Name: ____ Relation: ______________ Phone:____________

Name: ____ Relation: ______________ Phone:____________

______ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

____ ______________
Patient Name (Print) Date

____
Patient or Guarantor (Signature)