



CALIFORNIA HEMATOLOGY ONCOLOGY MEDICAL GROUP

Wade Nishimoto, MD.

Alex Makalinao, MD. Frank Mori, MD.

Allan Orenstein, MD. Jenny Ru, MD

Dear Patient,

Welcome to California Hematology Oncology Medical Group. It goes without saying that the diagnosis of a hematological disorder **or** cancer can cause great concern. Rest assured that our physicians and staff are extraordinarily well trained with knowledge of the most up to date therapies available. We will work together to help you to achieve health and healing.

Complete the following in order to help us serve you better:

1. **Completed copy of Assignment of Benefits and Treatment Consent Form (attached).**
2. **Insurance card(s)**
3. **Copayment**
4. **Authorization** (if necessary)
5. **All medical records** (in order to create the best treatment plan for you, your doctor will need to know as much as possible about you and your health).
6. **Completed copy of the Health Questionnaire (attached).** (One of the best ways of getting more information regarding your diagnosis and treatment is to talk to your doctor and ask him lots of questions. The doctors at California Hematology Oncology Medical Group will explain your diagnosis and treatment very thoroughly; however, it is sometimes hard to remember what the doctor tells you. You may want to write down a list of questions to ask your doctor the next time you come to the office. Your doctor will be happy to answer any questions you may have. It is also important to discuss with your doctor (or the nurse) any side effects of treatment you are experiencing, any physical changes, and any medications/supplements/herbs you are taking.)
7. **Please arrive 10 minutes before your appointment to fill out any additional paperwork.** (These appointments are carefully arranged to ensure that all patients receive the highest standard of care and attention. We do encourage you to be prompt for your appointments, as a latecomer may affect the smooth operation of the office. In certain cases, you may be asked to reschedule to another day. If you cannot keep your appointment, please give the office plenty of notice so that you may be given another appointment.)
8. **For the health and safety of our patients, we do not allow children under the age of 16 years in our office.**

Thank you for taking part in your care. We look forward to seeing you soon.

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PATIENT HISTORY QUESTIONNAIRE

| PATIENT INFORMATION | | | | | |
|--|------------|--------------------------|---|------------|----------------------|
| Patient Name: | | | | | |
| Today's Date: | | Patient's Date of Birth: | | | |
| REASON FOR VISIT | | | | | |
| | | | | | |
| CURRENT SYMPTOMS | | | | | |
| Please mark with an (x) any illnesses or medical problems you have, or have had, within the past year | | | | | |
| SYMPTOMS | (X) | MONTH STARTED | SYMPTOMS | (X) | MONTH STARTED |
| Sleep Difficulties | | | Change in Vision | | |
| Frequent or severe headaches | | | Eyeglasses needed | | |
| Fainting spells | | | Sinus trouble | | |
| Dizziness on change of position | | | Hay fever | | |
| Unconscious spells | | | Recurrent sore throats | | |
| Blurred vision | | | Recurrent mouth sores | | |
| Earaches | | | Soreness/bleeding gums | | |
| Discharge from ears | | | Dentures | | |
| Ringing in ears | | | Night sweats | | |
| Decrease in hearing | | | Palpitations/fluttering of heart | | |
| Recurrent nose bleeds | | | High blood pressure | | |
| Strange taste or loss in taste | | | Swelling of hands/feet/ankles | | |
| Persistent hoarseness | | | Leg cramps while walking or reclining? | | |
| Difficulty swallowing | | | At what time of day? | | |
| Enlarged glands | | | Enlarged veins in legs | | |
| Chest pain | | | Nausea or vomiting | | |
| Angina Pectoris | | | Shortness of breath when: | | |
| Coughed up blood | | | Walking several blocks | | |
| Chronic or frequent cough | | | Ascending a flight of stairs | | |
| Chronic or frequent cough when lying down | | | Lying down or reclining | | |
| Wake up nights, short of breath | | | Bluish or purple lips or fingers | | |
| How many bed pillows at night? | | | Rectal pain with bowel movement | | |
| Belching or heartburn relieved by Food or medication | | | Blood in bowel movement | | |
| Appetite: Good Fair Poor? | | | Full bladder feeling but little urination | | |
| Abdominal cramping | | | Urinate less than usual | | |
| Change in bowel movement | | | Pain on urinating | | |
| Getting up at night to urinate? | | | Difficulty in starting urination | | |
| Recurrent backaches or pain | | | Blood in urine? | | |
| Joint pain | | | Discharge from penis/vagina | | |
| Swelling of any joints | | | Sexual concerns/problems? | | |

| SYMPTOMS | (X) | MONTH STARTED | SYMPTOMS | (X) | MONTH STARTED |
|--|-----|---------------|---------------------------------------|-----|---------------|
| Loss or change in sensation of hands or feet | | | Tingling or weakness of hands or feet | | |
| Trembling of any extremity | | | Redness or heat in joints | | |
| Growth in neck or throat | | | Muscle spasms | | |
| Fatigue without obvious reason | | | Easy bruising | | |
| Inability to tolerate cold | | | Inability to tolerate heat | | |
| Stress? <input type="checkbox"/> Yes <input type="checkbox"/> No [if yes, list cause(s)] | | | | | |
| Do you have any ALLERGIES? If yes, please list: | | | | | |

PAST MEDICAL HISTORY

Please circle any illnesses or medical problems you have now or have had in the past and indicate the year each started. If this has occurred within the last 3 years, add an asterisk (*).

| ILLNESS | Year | ILLNESS | Year | ILLNESS | Year |
|--------------|------|-------------------------------|------|------------------|------|
| Polio | | Rheumatic fever/heart disease | | Nephritis | |
| Meningitis | | Bursitis/sciatica/lumbago | | Bladder disorder | |
| Influenza | | Neuritis/neuralgia | | Arthritis | |
| Rheumatism | | Pleurisy | | Joint disease | |
| Gonorrhea | | Bone disease | | Tuberculosis | |
| Jaundice | | Gallbladder disease | | Anemia | |
| Diabetes | | Migraine headaches | | Syphilis | |
| Colitis | | Bowel disease | | Epilepsy | |
| HIV positive | | Hemorrhoids | | Cancer | |
| AIDS | | Frequent infection | | Asthma | |
| | | Nervous breakdown | | Panic attacks | |
| Other | | | | | |

FOR WOMEN ONLY

| | | | |
|---|--|--------------------------------|--|
| Onset of Menarche (first menstrual period): | | Date of Last Menstrual Period: | |
| Date of Last PAP Smear: | | Date of Last Mammogram: | |
| Number of Pregnancies: | | Number of Live Births: | |
| Date of first pregnancy: | | | |
| Vaginal Discharge? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Using Oral Contraceptives? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

WEIGHT HISTORY

| | | | |
|---------------------|--|---------------------|--|
| Recent weight loss? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight gain? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Amount: | | | |

MEDICATION & SUBSTANCE USE

| | Never | Past | Occasionally | Frequently | Daily | If Current, list again with <i>Current Medications/Supplements</i> below |
|-------------------------|-------|------|--------------|------------|-------|--|
| Laxatives | | | | | | |
| Tranquilizers/Sedatives | | | | | | |
| Sleeping pills | | | | | | |
| Appetite depressants | | | | | | |
| Street Drugs | | | | | | |
| Tobacco | | | | | | |
| Alcohol | | | | | | |

HOSPITALIZATIONS

List all hospitalizations, operations, tests, procedures and severe injuries.

| Date | Type of operation, test, procedure and severe injury | Physician and Medical Facility |
|------|--|--------------------------------|
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RECENT DIAGNOSTIC TESTS

| Specify: | CAT SCANS/X-Rays: Date(s) | PET SCANS/Bone Scans: Date(s) | Ultrasound/Date(s) | MRI/Date(s) | Medical Facility |
|----------|---------------------------|-------------------------------|--------------------|-------------|------------------|
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Additional studies:

Have you ever been advised to have a test, procedure, or surgery, but decided against it? No Yes
If "yes" please explain:

FAMILY HISTORY

Has any blood relative ever experienced any of the following conditions?

| Cancer | | | | | | |
|--|-----|----------------|-----------|--------------|---------------|----------------|
| Blood disorders/leukemia: | | | | | | |
| Immediate Family | Age | Present health | Deceased? | Age at death | Year of death | Cause of death |
| Father | | | | | | |
| Mother | | | | | | |
| Brother <input type="checkbox"/> Sister <input type="checkbox"/> | | | | | | |
| Brother <input type="checkbox"/> Sister <input type="checkbox"/> | | | | | | |
| Brother <input type="checkbox"/> Sister <input type="checkbox"/> | | | | | | |
| Brother <input type="checkbox"/> Sister <input type="checkbox"/> | | | | | | |
| Brother <input type="checkbox"/> Sister <input type="checkbox"/> | | | | | | |
| Husband/Wife | | | | | | |
| Children and their names | | | | | | |
| | | | | | | |
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CURRENT MEDICATIONS/SUPPLEMENTS

List all medications, vitamins, or supplements you are now taking, including those you buy with/without a doctor's prescription

| Name | Dosage | Times per Day | Reason |
|------|--------|---------------|--------|
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Hormones (specify: thyroid, estrogen, testosterone, etc.) If yes, for what?

Steroids (specify: cortisone, ACTH, etc.) If yes, for what?

COMPLEMENTARY & ALTERNATIVE THERAPIES

Have you ever been treated with any complementary and/or alternative therapies (acupuncture, massage therapy, chiropracty etc.) If so, please list below:

If you have stopped any of these therapies, please list reason(s) why:



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ASSIGNMENT OF BENEFITS AND TREATMENT CONSENT

I understand that my health information may be used for treatment, payment, and health care operations purposes and I have the right to receive a notice of information practices, to see a copy of my own health information, to amend my health information if it is inaccurate and to receive an accounting of disclosures. _____

I hereby authorize California Hematology Oncology Medical Group to furnish my Insurance Company all information, which said Insurance Company might request concerning my illness/injury/therapy.

I hereby authorize California Hematology Oncology Medical Group all payments to which I am entitled for Medical and/or Surgical expenses relative to the service reported for the above.

I understand I am financially responsible to said Doctor(s) for co-payments and charges not covered by this assignment.

I understand that if my insurance coverage lapses for whatever reason, I will be financially responsible for all services rendered.

I hereby authorize California Hematology Oncology Medical Group Physicians to render my medical treatment, laboratory testing, and x-rays as deemed necessary by my physician.

I accept the responsibility for all financial matters including insurance eligibility confirmation and timely payment from my insurance company. I understand that if I do not provide the correct insurance information I can be held responsible for payment of the charges incurred for physician visits and/or chemotherapy visits.

Patient Name: _____

Date: _____ Signed: _____

Relationship to Patient: _____