CALIFORNIA HEMATOLOGY ONCOLOGY MEDICAL GROUP
Wade Nishimoto, MD. Alex Makalinao, MD.
Frank Mori, 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 <u>do not allow</u> 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 Name: _____ DOB: _____ Age: _____ M/F

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Do you reside in an assisted living/nursing home facility? ☐ Yes ☐ No

Email Address: _____ Cell Phone#: _____

SS# _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Employer: _____

Work Address: _____

Work Phone: _____ Occupation: _____

Spouse Name: _____ DOB: _____ M/F

Home Phone: _____ SS#: _____

Current Employer _____

Work Address: _____ Work Phone: _____

Emergency Contact (not spouse) _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____

Primary Physician: _____ Other Physician: _____

Telephone Number: _____ Telephone Number: _____

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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 herby 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 herby 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 charger 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 herby 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:_____

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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? ☐Yes ☐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?	☐Yes ☐No	Using Oral Contraceptives?	☐Yes ☐No

WEIGHT HISTORY

Recent weight loss?	☐Yes ☐No	Recent weight gain?	☐Yes ☐No
Amount:			

MEDICATION & SUBSTANCE USE

	Never	Past	Occasionally	Frequently	Daily	If Current, list again with *Current Medications/Supplements* 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

RECENT DIAGNOSTIC TESTS

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

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 ☐ Sister ☐						
Brother ☐ Sister ☐						
Brother ☐ Sister ☐						
Brother ☐ Sister ☐						
Brother ☐ Sister ☐						
Husband/Wife						
Children and their names						

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

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: