ILLINOIS CANCER SPECIALISTS

Illinois Cancer Specialists.com

Dear Patient,

Welcome to Illinois Cancer Specialists. To make your visit go more smoothly, we have included a New Patient Welcome Packet for your benefit. Please complete the following enclosed forms:

- **ASSIGNMENT OF BENEFITS FORM:** allows us to accept payment from your insurance.
- **HIPAA FORM:** indicates to whom we can release your medical information.

In addition to the above, completed forms, please bring the following with you to your appointment:

-LIST OF QUESTIONS OR CONCERNS

-LIST OF ALL CURRENT MEDICATIONS: include over the counter and herbal drugs. In lieu of a list, you may bring in your pill bottles.

-MOST RECENT INSURANCE AND PRESCRIPTION CARDS, referral from primary care physician when necessary

-PREFERRED PHARMACY INFORMATION. Name, address, and phone number.

VISITORS: Illinois Cancer Specialists welcomes your friends or loved ones to visit during your treatment. Together, we share a common desire to create a safe and comfortable environment for your treatment or office visit. For the safety of our patients and staff, Illinois Cancer Specialists asks that you limit visitors to 1-2 people and do not allow children in the lab or treatment areas. Children must remain in the main lobby area and accompanied by a parent or guardian at all times. Thank you for your cooperation.

You will find answers to many questions you may have in the "General Information" handout; however, should you have questions which are not addressed, feel free to call our office or ask any staff member during your visit.

Sincerely,
Illinois Cancer Specialists

GENERAL INFORMATION

THE INFORMATION TO THE RIGHT WILL ACQUAINT YOU WITH OUR SERVICES AND OFFICE PROCEDURES. OUR GOAL IS TO PROVIDE YOU WITH USEFUL INFORMATION THAT WILL HELP YOU UTILIZE OUR CENTER.

OUR PHYSICIANS ARE ON-CALL FOR EMERGENCIES AFTER HOURS AND DURING THE WEEKEND. CALL THE OFFICE NUMBER TO BE CONNECTED WITH THE PHYSICIAN ON CALL.

YOUR FIRST APPOINTMENT

Please help us by arriving at your appointment at the time requested by our staff. In addition to the completed forms in your welcome packet, please bring the following items with you to your appointment:

1. List of your questions or concerns
2. Your current medications (including over-the-counter and herbal medications) - please bring either a list or the actual bottles
3. Current insurance and prescription cards
4. Your preferred pharmacy information: name, address, and phone number

NURSE/PHYSICIAN

All calls to our nurses are routed through the Triage Nurse. Please leave a detailed message with your full name (including the spelling of your last name), date of birth, reason for calling, and a number where you can be reached. Every effort will be made to return your call as soon as possible, and our goal is to return your call the same day. If it is important that your call be returned within a certain amount of time (example; need a call back within 2 hours) you must make that clear in your message.
IF YOUR SITUATION REQUIRES IMMEDIATE ATTENTION, DO NOT CALL THE OFFICE; DIAL 911.

PRESCRIPTION REFILLS

Refills of prescription drugs can only be filled during regular business hours. This restriction is for your protection: we must be able to have access to your most up-to-date and complete medical records to ensure you receive appropriate medications and approvals from your physician.

SCHEDULING AND APPOINTMENTS

If you are calling to schedule an appointment and do not reach us, please leave a detailed message including the following information:

1. Full name (including spelling of last name)
2. Date of birth for the patient
3. Phone number where you can be reached

Please call the office and speak with the nurse before coming in for an unscheduled visit. We will always accommodate emergencies when they occur. For this reason it is very important to always schedule your visits so that time can be set aside for your care.

If you cannot keep a scheduled appointment please let us know as soon as possible so that we can release that time for another patient.

Please pay close attention to your appointment time and help us by arriving at the time designated on your appointment card. Please understand that in order to be respectful of those patients who do arrive at their scheduled times, late arrivals will be worked into the schedule as it allows. Additionally, those who arrive more than 30 minutes before their appointment will be asked to wait.

INSURANCE AND BILLING

You will be asked to provide us with your insurance coverage information at your first visit and every visit thereafter. A day or two prior to your first appointment with our office, a registration clerk will contact you to obtain and verify your insurance information.

It is a requirement of your health insurance that co-payments be collected at each visit.

We participate with most major insurance carriers. As a courtesy, claims will be filed for you. In order to ensure reimbursement, your insurance information must be kept current. Please remember that your insurance policy is a contract between you and your insurance company and we are not a party to the contract. For your convenience we accept Visa, MasterCard, Discover, and American Express.

If there is a patient responsibility due, you will receive monthly statements showing you an itemization of charges and payments made by you or your insurance company. You will be introduced to one of our Patient Financial Counselors who will assist you with your financial health.

If you have questions regarding your billing, do not hesitate to contact our billing office at (847) 585-7000.

ADDITIONAL RESOURCES

Please visit the official website for Illinois Cancer Specialists at IllinoisCancerSpecialists.com for more information. There you can explore the Resource Center, get directions, and find valuable links to other websites.

If you have any questions, at any time, do not hesitate to ask a ICS staff member or call our offices where we will be happy to assist you.

OFFICE LOCATIONS

Arlington Heights
880 West Central Road
Suite 8200
Arlington Heights, IL 60005
(847) 259-4482

Chicago/Resurrection
7447 W. Talcott Ave.
Suite 400
Chicago, IL 60631
(773) 763-9300

Elgin
1710 N. Randall Road
Suite 300
Elgin, IL 60123
(847) 931-0909

Hoffman Estates
1555 Barrington Road
Suite 235
Hoffman Estates, IL 60169
(847) 885-0909

Huntley
10350 Haligus Road
Suite 210
Huntley, IL 60142
(847) 802-7880

McHenry
4305 Medical Center Drive
Suite 1
McHenry, IL 60050
(815) 363-0066

Niles
8915 W. Golf Road
Niles, IL 60714
(847) 827-9060

Woodstock
3703 Doty Road
Suite 6
Woodstock, IL 60098
(815) 334-9154

OUR TEAM

OUR CANCER CARE TEAM IS MADE UP OF BOARD-CERTIFIED ONCOLOGISTS AND OTHER ONCOLOGY-TRAINED CLINICAL PROFESSIONALS WHO UNDERSTAND THE SPECIAL NEEDS OF CANCER PATIENTS AND THEIR FAMILIES.

With many years of experience caring for cancer patients, our physicians, nurses, pharmacists, counselors and other specialists work together to provide world-class, personalized cancer care.

MEDICAL ONCOLOGY & HEMOTOLOGY

Our medical oncology team plays a major role in cancer care by managing treatment plans and therapies, monitoring and evaluating progress, and collaborating on best options with other caregivers. We consult with patients on their choices and any temporary side effects they may experience during chemotherapy treatments, as well as offer medical guidance to help patients make decisions along the way.

Our hematology team has extensive experience providing high quality patient care, research, and leading-edge treatment of blood and bone marrow disorders; for both cancer and non-cancer patients.

These ICS physicians are trained in the specialties of both medical oncology and hematology.

Dr. Lisa Baddi
Dr. Susan G. Brown
Dr. Bety Ciobanu
Dr. Jay S. Dalal, FACP
Dr. John W. Eklund
Dr. Robert Galamaga
Dr. David Hakimian
Dr. Leonard M. Klein
Dr. Rajat Malhotra
Dr. Robert Mandal
Dr. Rajini Manjunath
Dr. Stan Nabrinsky
Dr. Randy S. Rich
Dr. Joel Schwartz
Dr. Richard S. Siegel
Dr. Veerpal Singh
Dr. Urszula A. Sobol
Dr. Alexander Starr
Dr. C. Yeshwant
Dr. Aslam S. Zahir

RADIATION ONCOLOGY

Today, radiation therapy is quicker, safer and more precise than ever before. Our radiation oncology team uses advanced treatment planning systems and state-of-the-art radiation technology to deliver internal and external radiation to cancerous cells, which helps prevent them from growing or dividing and spreading.

Dr. Joel Schwartz

ADVANCED PRACTICE NURSES & PHYSICIANS ASSISTANTS

Many of our sites have at least one Nurse Practitioner or Physicians Assistant on site. Patients may interface with them in between physician visits.

Often described as an art and a science, nursing is a critical link between our patients and physicians. Our nurses have many roles, from educator to practitioner and researcher, and serve all of them with passion for the profession and with a strong commitment to patient safety.

Website:
IllinoisCancerSpecialists.com

SERVICES

WHEN FACED WITH CANCER, PATIENTS WANT THE MOST ADVANCED CARE AVAILABLE. Thanks to the dedication of our experienced physicians and staff, Illinois Cancer Specialists provides unparalleled access to innovative therapies and the latest technologies based on the latest clinical evidence—right here in our community. From leading-edge diagnostic imaging and sophisticated radiation therapies, to new investigational drugs through clinical trials, we offer our patients advanced and comprehensive cancer care.

To us, providing comprehensive care also means understanding that having cancer is hard on patients and their families. Our physicians and staff will do whatever it takes to make everyone more comfortable. We will spend time with our patients to make sure they understand their diagnosis and treatment options, and offer educational resources and support services designed to help patients and their families understand and cope with their disease.

Services offered at Illinois Cancer Specialists include:

Medical Oncology
Radiation Oncology
Hematology
Oncology Clinical Nursing
Stem Cell Transplantation
Hormone Therapy
Immunotherapy
Chemotherapy
PET/CT
Pharmacy
Clinical Laboratory Services
Clinical Studies/Research Trials
Therapeutic Phlebotomy
Genetic Testing
Genetic Counseling
Access to Clinical Social Worker
Patient Financial Counselors
Educational Resources
Home Care Support Referral
Hospice Care Referral
Palliative Care

MISSION STATEMENT

TO DELIVER ON THE PROMISE OF PROVIDING THE BEST PATIENT CARE POSSIBLE IN A CARING AND SUPPORTIVE ENVIRONMENT WITH SEAMLESS ACCESS TO THE LATEST IN TECHNOLOGY AND RESEARCH AVAILABLE TO HELP EVERY PATIENT LIVE THEIR HIGHEST QUALITY OF LIFE.

PATIENT RIGHTS AND RESPONSIBILITIES

AS A PATIENT I HAVE THE RIGHT TO RECEIVE AN EXPLANATION OF MY DIAGNOSIS, BENEFITS OF TREATMENT, ALTERNATIVES, RECUPERATION, RISKS AND AN EXPLANATION OF CONSEQUENCES IF TREATMENT IS NOT PURSUED.

RIGHTS

As a patient I have the right to:

- Full information about my rights and responsibilities as a patient at ICS.
- Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
- An explanation of all rules, regulations and services provided by ICS, the days and hours of services and provisions for possible emergency care, including telephone numbers
- Choose my own physician/care giver, and know the names, status and experience of the staff.
- Participate in development of a plan of care and receive information on Advance Directives.
- Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previously given consent for further treatment
- Disclosure of any teaching programs, research of experimental programs in which the facility is participating
- Financial explanation and estimated cost for my plan of care prior to beginning treatment.
- Receive expert, professional care without discrimination, regardless of age, creed, color, religion, national origin, sexual preference, or handicap
- Be treated with courtesy, dignity and respect of my personal privacy by all employees of ICS
- Be free of physical/mental abuse and/or neglect by all employees of ICS
- Complain or file grievance with ICS practice manager without fear of retaliation or discrimination
- Access to my personal records and obtain copies upon written request
- Assistance and consideration in the management of pain

RESPONSIBILITIES

As a patient I have the responsibility to:

- Disclose accurate and complete information of my physical condition, hospitalizations, medications, allergies, medical history and related items
- Participate in developing a plan of care, advance directives and living will
- Assist in maintaining a safe, peaceful and efficient ambulatory environment
- Provide new/changed information related to my health insurance to the business office
- Contact ICS when unable to keep a scheduled appointment
- Cooperate in the planned care and treatment developed for me
- Request more detailed explanations for any aspect of service I do not understand
- Inform my physicians and nurses of any changes in my condition or any new problems or concerns
- Communicate any temporary or permanent changes in my address or telephone number which might hinder contact by the staff
- Relate my levels of discomfort and/or pain and perceived changes in my pain management to my physician

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ ( ) – _____
Last First MI *Home Telephone*

( ) – _____
Cell Phone

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City State Zip *City State Zip*

DOB: _____ Age: ____ ☐M ☐F SS#: _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Check Marital Status*

Employer: _____ ( ) – _____
Name *Telephone*

_____ _____
Address *Occupation*

Responsible Party: _____ ( ) – _____
Name Relationship *Telephone*

Emergency Contact: _____ ( ) – _____
Name Relationship *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ ID #: _____ Group #: _____

Insured Name: _____ DOB: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Insured Name: _____ DOB: _____

Pharmacy Insurance: _____ ID #: _____

RxBIN: _____ RxPCN: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Illinois Cancer Specialists.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Illinois Cancer Specialists. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Illinois Cancer Specialists.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Illinois Cancer Specialists.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Date/Time AM or PM (circle one)

PHYSICIAN: _____
ACCOUNT NUMBER: _____ LOCATION: _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS: _____

ILLINOIS CANCER SPECIALISTS
Illinois Cancer Specialists.com

Effective Date: 01 JAN 2018

HIPAA AUTHORIZATION

Date: _____

MRN: _____

Name: _____ **Date of Birth**: _____

Authorized Individual Release

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Please indicate below your preferred method of contact.

☐ Home Phone: _____ Can we leave a detailed message? ☐ Yes ☐ No

☐ Cell Phone: _____ Can we leave a detailed message? ☐ Yes ☐ No

☐ Work Phone: _____ Can we leave a detailed message? ☐ Yes ☐ No

_____ _____

Patient Signature Date

Authorized Release to Others

I authorize Illinois Cancer Specialists to release my medical information to person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain or review my medical information and have my permission to discuss my care or obtain results/information on my behalf. I authorize the person(s) indicated below to pick-up materials pertinent to my medical care.

Name of Primary Point-of-Contact	Relationship	Telephone

Name of Secondary Point-of-Contact	Relationship	Telephone

Additional Point-of-Contact(s)	Relationship	Telephone

Check One:

☐ **I CONSENT TO RELEASE TO OTHERS**

☐ **I REFUSE RELEASE TO OTHERS** – I do not authorize release or disclosure to my spouse, family member, or personal representative at this time. I may review this decision in writing at a later date, if I so choose.

_____ _____

Patient Signature Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual by the individual.

Note: Uses and disclosures for treatment purposes only may be permitted without prior consent in an emergency.

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

DATE: _____

DEMOGRAPHICS

Name: _____ **Date of Birth**: _____

Ethnicity (optional): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional):

☐ White ☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Native Hawaiian
☐ Chinese ☐ Guamanian or Chamorro ☐ Korean ☐ Filipino ☐ Vietnamese
☐ Samoan ☐ Other Asian (Please state): _____ ☐ Other Race: _____

Sex: ☐ Male ☐ Female

PREFERRED LANGUAGE

Is English your preferred Language? ☐ Yes
☐ No, What is your preferred language? _____

MAIN PROVIDER

Primary Care Physician: _____ Phone Number: _____
Referring Physician: _____ Phone Number: _____

Current problem or reason for consultation: _____

VACCINATIONS

Vaccination	Last Administration Date (MM/YYYY)
Pneumonia	
Flu	
Shingles	
Pneumococcal	
Tuberculosis (TB)	

Vaccination	Last Administration Date (MM/YYYY)
Hepatitis B	
DT	
DPT	
Tetanus	
Other	

PAST MEDICAL HISTORY: PLEASE CHECK ALL THE BOXES THAT APPLY

☐ Anemia/Blood disorders
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Blood Clots
☐ Cancer
☐ Cataracts
☐ Colitis
☐ Diabetes
☐ Emphysema
☐ GERD
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis/Liver disease
☐ Hypercholesterolemia
☐ Hypertension
☐ Irregular heartbeat
☐ Kidney disease
☐ Pancreatitis
☐ Sickle Cell disease
☐ Sinusitis
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Ulcers
☐ Other: _____

Any unusual childhood infections or illnesses? _____

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

MEDICAL SURGICAL HISTORY

Operation	Date (MM/YYYY)	Reason	Surgeon/Facility

HOSPITALIZATION

Have you been hospitalized with in the last year? ☐ Yes ☐ No

If yes, please describe reason, facility and dates: _____

SCREENING TESTS

Have you had any screening tests?

Screening Test	Completed	Date	Results
Mammogram	☐ Yes ☐ No ☐ N/A		
Breast Exam	☐ Yes ☐ No ☐ N/A		
Pap Smear/Pelvic Exam	☐ Yes ☐ No ☐ N/A		
Stool for Occult Blood	☐ Yes ☐ No ☐ N/A		
Colonoscopy/Sigmoidoscopy	☐ Yes ☐ No ☐ N/A		
Prostate Exam	☐ Yes ☐ No ☐ N/A		
PSA	☐ Yes ☐ No ☐ N/A		
Chest X-Ray/CT (Smokers)	☐ Yes ☐ No ☐ N/A		
Bone Density	☐ Yes ☐ No ☐ N/A		
Dermatology Skin Screening	☐ Yes ☐ No ☐ N/A		
Eye Exam	☐ Yes ☐ No ☐ N/A		
Other: _____			

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

SOCIAL HISTORY

Number of Children: _____

Age/Sex of Children: _____

Spouse/Partner's Name: _____

ALCOHOL USE

Do you drink beer, wine, or liquor? ☐ Yes ☐ No

If yes, How many drinks per:

Day: _____ Week: _____ Month: _____ Year: _____

Did you quit? ☐ Yes ☐ No

When did you quit? _____

Have you ever sought help for drinking? ☐ Yes ☐ No

SMOKING USE

Do you currently smoke? ☐ Yes ☐ No

If yes, what do you smoke?

☐ Cigarettes How often per Day/Week: _____

☐ Cigars How often per Day/Week: _____

☐ Pipe How often per Day/Week: _____

☐ Electronic Cigarettes How often per Day/Week: _____

☐ Smokeless/Chewing Tobacco How often per Day/Week: _____

Did you ever smoke? ☐ Yes ☐ No

If yes, how long did you smoke for? _____

When did you quit? _____

Do you wear a nicotine patch? _____

DRUG USE (RECREATIONAL)

Do you use recreational drugs, including marijuana? ☐ Yes ☐ No

If yes, what do you use: _____

How often: _____

If marijuana, is it medical marijuana? ☐ Yes ☐ No

Have you previously used recreational drugs? ☐ Yes ☐ No

If yes, when did you quit: _____

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

PREFERRED PHARMACY

Please indicate the pharmacy you are currently using for your prescriptions. If you are using a mail order pharmacy, specialty pharmacy or another pharmacy out of state, please include that information as well.

Pharmacy Name: _____ Type (circle one): Retail Mail Order Specialty
Address/Cross Roads: _____
City:_____ State: _____ Zip Code: _____
Phone number: _____ Fax number: _____

Pharmacy Name: _____ Type (circle one): Retail Mail Order Specialty
Address/Cross Roads: _____
City:_____ State: _____ Zip Code: _____
Phone number: _____ Fax number: _____

MEDICATION LIST

Please list all the medications you are currently taking. Be sure to include the dosage, how often and the doctor that has prescribed this medication for you. If you are taking any vitamins, over the counter medications or herbal supplements please also include these medications in the list below (you do not need to include the prescribing physician if not applicable).

PRESCRIPTION / OVER-THE-COUNTER			
Drug Name	**Dose/Strength of Medication**	**How often you take Medication**	**Prescribing Physician**

Please list any herbal supplements you are currently taking (probiotics, vitamins, etc.).

Herbal Supplements	Dose/Strength	How often you take Supplement

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please list any medications, food or substances that you are allergic to. If applicable, please list the reaction (i.e. swelling, itching, shortness of breath, etc.)

Name of medication, food or substance:	Type of Reaction:

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

FAMILY MEDICAL HISTORY

Please mark (Y) for all those that apply to YOUR FAMILY. Please mention relationship(s) to you and the age of diagnosis for each cancer in your family.

The following close blood relatives should be considered: You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first cousins, great grandparents & great grandchildren.

YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF DIAGNOSIS	PARENTS / SIBLINGS / CHILDREN	AGE of Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE of Diagnosis	RELATIVES on your FATHER'S SIDE	AGE of Diagnosis
☒ Y ☐ N	EXAMPLE: BREAST CANCER		---	---	Aunt Cousin	45 61	Grandmother	53
☐ Y ☐ N	BREAST CANCER (Female or Male)							
☐ Y ☐ N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
☐ Y ☐ N	UTERINE (ENDOMETRIAL) CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLORECTAL POLYPS (Specify #)							
☐ Y ☐ N	OTHER CANCER(S) (Specify cancer type)							

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
(Please explain/include a copy of result if possible)

For other close blood relatives such as grandparents, aunts and uncles: Please check all boxes that apply

- ☐ Anemia/Blood Disorders
- ☐ Blood Clots
- ☐ Blood Disorders
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

REVIEW OF SYSTEMS

General	☐ Fever	☐ Weight Loss	☐ Fatigue
	☐ Chills	☐ Weight Gain	☐ Night Sweats
Head	☐ Headaches	☐ Ringing in ears	☐ Toothache
	☐ Blackouts	☐ Sinusitis	☐ Double Vision
	☐ Seizures	☐ Post Nasal Drip	☐ Blurred Vision
	☐ Dizziness	☐ Sore Throat	☐ Cataracts
	☐ Hearing Loss	☐ Hoarseness	☐ Glaucoma
	☐ Earache	☐ Sore Tongue	
	☐ Bleeding Gums	☐ Nosebleeds	
Neck	☐ Lumps	☐ Goiter	☐ Pain or Stiffness
	☐ Pain when swallowing	☐ Difficulty swallowing	
Chest	☐ Cough	☐ Shortness of Breath	☐ Heart Murmur
	☐ Sputum	☐ Chest Pain	☐ Rheumatic Fever
	☐ Coughing Up Blood	☐ Palpitations	☐ High Blood Pressure
	☐ Wheezing	☐ Swelling of feet	
	☐ Bronchitis	☐ Asthma	
Breast	☐ Lumps	☐ Pain	☐ Nipple Discharge
Abdomen	☐ Nausea	☐ Ulcer	☐ Hemorrhoids
	☐ Vomiting	☐ Gas	☐ Blood in stools
	☐ Indigestion	☐ Bloating	☐ Black stools
	☐ Abdominal pain	☐ Constipation	
	☐ Hiatal Hernia	☐ Diarrhea	
Urinary	☐ Blood in urine	☐ Difficulty starting to urinate	☐ Getting up at night to urinate
	☐ Burning with urination	☐ Bladder/Kidney Infections	☐ Sense of full bladder
	☐ Frequent urination		
Gynecology	☐ Spotting	☐ Cramping	☐ Discharge
	☐ Vaginal infections		
	Last Menstrual Period: _____	Duration: _____	Interval: _____
	Number of pregnancies: _____	Number of live births: _____	
Skin	☐ Rash	☐ Itching	☐ Change in hair or nails
Neuromuscular	☐ Joint Stiffness	☐ Swelling	☐ Night Cramps
	☐ Joint Pain	☐ Back Pain	☐ Varicose veins
Hematological	☐ Easy bruising or bleeding	☐ Anemia	☐ Past Infusion
			☐ Transfusion Reactions
Endocrine	☐ Thyroid Problems	☐ Hot or cold intolerance	☐ Excessive thirst or hunger
Psychiatric	☐ Anxiety	☐ Depression	☐ Memory Loss
	☐ Nervousness		

ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

OTHER PROVIDERS

Please list all providers involved in you care within the last 3 years:

Provider Type	Physician (first and last name)	Phone Number
Primary Care Physician		
Surgeon		
Cardiologist		
Endocrinologist		
Neurologist		
Urologist		
Pulmonologist		
Dentist		
Oral surgeon		
Optometrist		
Orthopedic		
Gynecologist		
Podiatrist		
Dermatologist		
Rheumatologist		
Other: _____		

Patient Signature: _____ **Date**: _____