AdventHealth

Patient Information Form

Today's Date:_____ Name:_____

Date of Birth:_____ Primary Doctor:_____

Referring Doctor:_____ Other Doctors:_____

Preferred Pharmacy:_____ Preferred Lab: _____

What is your occupation? _____

Any barriers to learning? Please explain: _____

Tobacco/Smoking: ☐ Current ☐ Never ☐ Past

Quit (date) _____

Alcohol: ☐ Current ☐ Never ☐ Past

Substance Abuse: ☐ Current ☐ Never ☐ Past

Caffeine: ☐ Current ☐ Never ☐ Past

PICC/PORT: ☐ Yes ☐ No

Current problems:_____

_____

Allergies: _____

_____

_____

Social History: Race:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ _____

Number of Children:_____ Number of Pregnancies:_____

Do you feel safe in your current home environment? ☐ Yes ☐ No (If No, explain)_____

_____

Do you have an advanced directive? (If so, please list)_____

Family History: Please list any major medical problems and/or cause of death or changes since last visit

Relative	**Medical Problem(s)/Cancer(s)/Cause of Death if applicable**
Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Sister(s)	
Brother(s)	
Children	
(Please specify M or F)	

(For Office Use Only)

Temp: _____ BP: _____ Pulse: _____ Resp: _____ 02: _____ Height: _____ cm Weight:

MSCSDMRPT

Surgical History: Please list any surgeries that you have had, along with the date performed since last visit

_____

_____

_____

Past Medical History (Please indicate date). Update if there are any changes since last visit:

Anemia _____	Epilepsy _____	Other Thyroid Disorder _____
Arthritis _____	Fibromyalgia _____	Pulmonary Embolism _____
Asthma _____	Glaucoma _____	Radiation Treatments _____
Autoimmune Disorder _____	Gout _____	Rheumatic Fever _____
Blood Pressure-High _____	Heart Attack _____	Rheumatoid Arthritis _____
Blood Pressure-Low _____	Heart Disorder _____	Scarlet Fever _____
Cancer (specify type) _____	Heart Pacemaker _____	Sleep Apnea _____
Chemotherapy _____	Hemophilia _____	Slow Healing Sores _____
COPD _____	Hyperthyroid _____	Stroke _____
Depression _____	Hypothyroid _____	None _____
Diabetes (Type 1) _____	Kidney (Renal Disease) _____	
Diabetes (Type 2) _____	Liver Disease _____	Other _____
DVT _____	Lupus _____	_____
Emphysema _____	Neuropathy _____	_____

Gynecologic History

Are you pregnant? ☐ Yes ☐ No ☐ NA When was your last period?_____

Date of last manual breast exam:_____

Date of last CA-125:_____ Result:_____

Date of last Pap smear:_____ Result:_____

Date of last mammogram:_____ Result: _____

Date of last colonoscopy:_____ Result: _____

Date of last imaging (CT scan/Ultrasound, X-ray, etc.): _____

Have you fallen in the past 3 months? ☐ Yes ☐ No Date of last Fall: _____

On a scale of 0-10, rate your pain (select):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Moderate Worst Possible Pain

Is the pain new or chronic? ☐ New ☐ Chronic Location of the pain_____

Check if you have any of the following, or check "No Symptoms"

General: ☐ No Symptoms

☐ Fever
☐ Chills
☐ Fatigue
☐ Malaise

Ear, Nose, Throat: ☐ No Symptoms

☐ Headache
☐ Ringing Ears
☐ Sinusitis
☐ Voice change
☐ Earache
☐ Nose bleeds
☐ Visual changes
☐ Neck pain
☐ Mouth Sores

Neurologic: ☐ No Symptoms

☐ Numbness
☐ Weakness
☐ Balance Problems
☐ Seizures

Respiratory: ☐ No Symptoms

☐ Cough
☐ Difficulty breathing at rest
☐ Difficulty breathing with activity
☐ Shortness of breath
☐ Wheezing

Cardiovascular: ☐ No Symptoms

☐ Chest pain
☐ Swelling
☐ Palpitations
☐ Syncope/Passing out

Urinary: ☐ No Symptoms

☐ Discharge
☐ Abnormal bleeding
☐ Pain
☐ Burning with urination
☐ Urinary frequency
☐ Blood in urine
☐ Pain with intercourse

Blood Disorders/Hematology: ☐ No Symptoms

☐ Easy bruising
☐ Swollen glands
☐ Easy bleeding

Skin: ☐ No Symptoms

☐ Itching
☐ Rashes
☐ Lesions
☐ Wounds

Immunologic: ☐ No Symptoms

☐ Asthma
☐ Contact dermatitis

Musculoskeletal: ☐ No Symptoms

☐ Back pain
☐ Bone pain
☐ Muscle weakness
☐ Arthritis
☐ Muscle pain

Psychiatric: ☐ No Symptoms

☐ Depression
☐ Anxiety
☐ Lack of energy

Gastrointestinal: ☐ No Symptoms

☐ Abdominal mass
☐ Abdominal pain
☐ Belching
☐ Bloating
☐ Blood in stool
☐ Change in bowel Habits
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea/Vomiting

Endocrine: ☐ No Symptoms

☐ Cold or heat intolerance
☐ Hot flashes
☐ Night sweats
☐ Increase thirst
☐ Weight change

LIST CURRENT MEDICATIONS

Name	Dose	Frequency

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) PLEASE PRINT

Today's Date:_____ Patient's SSN: _____

Patient Name: _____ Date of Birth: _____

Address:_____

Preferred Phone Number for Contact:_____

Describe the information you approve disclosure of:

☐ All aspects of my healthcare as allowed to me under applicable law.

☐ Other:_____

To whom you approve disclosure (spouse, family, friend…):

Name:_____ Relationship:_____

Phone #:_____ Address:_____

City:_____ State:_____ Zip Code: _____

Name:_____ Relationship:_____

Phone #:_____ Address:_____

City:_____ State:_____ Zip Code: _____

Name:_____ Relationship:_____

Phone #:_____ Address:_____

City:_____ State:_____ Zip Code: _____

- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may receive an accounting of disclosures as explained in Advent Health Shawnee Mission Cancer Institute's Notice of Patient Privacy Practices.
- I understand that my PHI may be disclosed for public policy purposes as stated in the Advent Health Shawnee Mission Cancer Institute's Notice of Patient Privacy Practices.
- I understand that Advent Health Shawnee Mission Cancer Institute may terminate its agreement to use or disclose any of my PHI at any time but only after I have received notice of such termination.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written authorization to the Health Management Department. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient or legal representative: _____

Printed name of legal representative:_____ Relationship to Patient: _____

Address and Phone number of legal representative: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____ MR#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ SS#: _____

To be completed by requester: ☐ Pick Up ☐ Mail ☐ Other: _____

If requested health information is needed for a doctor's appointment, please specify date: _____

The following individual or organization is authorized to make the following disclosure:

Name: AdventHealth Shawnee Mission Cancer Institute Phone: 913-632-9100
Address: 9100 W. 74th St. Fax: 913-632-9159
City: Shawnee Mission State: KS Zip Code: 66204

Admission/Discharge Date(s): _____

Forward to Health Information Management (Medical Records) for:

☐ *Abstract ☐ Discharge Summary ☐ Operative Report ☐ Emergency Department Report
☐ Pathology Report ☐ History & Physical ☐ Laboratory Report ☐ Radiology Report
☐ Consultation ☐ Other (specify) _____

Forward to Patient Business Office for: ☐ Billing Information **Forward to Cardiology Dept for:** ☐ Cath Lab Films

Forward to Radiology Dept for: ☐ X-ray films (specify) _____

Reason for requesting information: _____
Requests may be subject to copying fee

This information may be disclosed to and used by the following individual or organization:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed one year): _____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

Patient Signature: _____ Date: _____ Time: _____

Authorized Representative/Parent: _____ Date: _____ Time: _____

Printed Name of Authorized Representative/Parent: _____

Relationship to Patient: _____

Address and Phone # of Authorized Representative/Parent: _____

*Abstract consists of facesheet, history & physical, consults, operative notes, emergency record, lab, radiology, EKG reports, pathology, physical therapy and rehab. (if available).

AdventHealth

Home Diet

- ☐ Regular
- ☐ Bland
- ☐ Diabetic
- ☐ Dysphagia
- ☐ Fluid restriction
- ☐ Gluten free
- ☐ Kosher
- ☐ Low cholesterol
- ☐ Low fat diet
- ☐ Low sodium diet
- ☐ Mechanical soft
- ☐ No added salt
- ☐ Pureed
- ☐ Renal
- ☐ Vegetarian
- ☐ Other: _____

Feeding Ability

- ☐ Complete independence
- ☐ Modified independence
- ☐ Supervision
- ☐ Minimal assistance
- ☐ Moderate assistance
- ☐ Maximal assistance
- ☐ Total assistance
- ☐ Other

Eating Difficulties

- ☐ None
- ☐ Chewing
- ☐ Loose Teeth
- ☐ No Teeth
- ☐ Swallowing food
- ☐ Swallowing fluids
- ☐ Other

Supplements

- ☐ Herbal
- ☐ PO Nutritional
- ☐ Vitamin/Mineral
- ☐ Liquid nutrition supplements
- ☐ Other_____

Appetite

- ☐ Good (75-100%)
- ☐ Fair (50-75%)
- ☐ Poor (<50%)

Nutritional Risk Factors

	Yes	No
Constipation	☐	☐
Active Eating Disorder	☐	☐
Enteral Feedings	☐	☐
Geriatric Surgical Patient > 75 years old	☐	☐
Decreased Food and Fluid Intake	☐	☐
Unintentional Weight Change >10 lbs. within last month	☐	☐

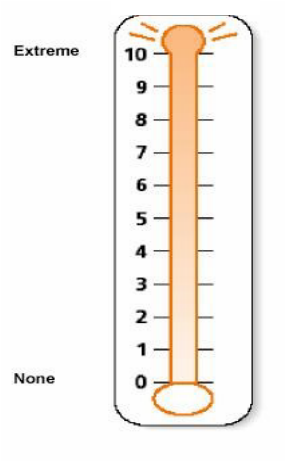
	Yes	No
Lactation	☐	☐
Frequent Nausea/Vomiting/Diarrhea in the Last 3 Days	☐	☐
Intake <50% of Normal in the Last 3 Days	☐	☐
Skin Breakdown/Decubitus Ulcers	☐	☐
TPN Feedings	☐	☐
Bariatric Surgery	☐	☐

Fatigue Assessment

In the past 7 days...	Never	Rarely	Sometimes	Often	Always	Unknown
How often have you felt tired?	☐	☐	☐	☐	☐	☐
How often did you experience extreme exhaustion?	☐	☐	☐	☐	☐	☐
How often did you run out of energy?	☐	☐	☐	☐	☐	☐
How often did your fatigue limit you at work?	☐	☐	☐	☐	☐	☐
How often were you too tired to think clearly?	☐	☐	☐	☐	☐	☐
How often were you too tired to take a bath or shower?	☐	☐	☐	☐	☐	☐
How often did you have enough energy to exercise strenuously?	☐	☐	☐	☐	☐	☐

Distress Screening

Distress



Distress is a term used to describe unpleasant feelings or emotions that may interfere with your ability to cope with your diagnosis. It can affect emotions, thoughts, behaviors, and how you interact with others. Distress is normal when you or a family member has a new diagnosis. AdventHealth offers this brief Distress Screen. It helps us provide you with ongoing support and the best care.

Please **CIRCLE** the number that best describes how much distress you have been experiencing in the **past week, including today.**

Please check if any of the following has been a cause of distress in the past week, including today.

Practical Concerns
- ☐ Transportation
- ☐ Insurance
- ☐ Financial
- ☐ Work
- ☐ School
- ☐ Childcare
- ☐ Treatment decisions

Emotional Concerns
- ☐ Depression
- ☐ Anger
- ☐ Anxiety
- ☐ Sadness
- ☐ Worry
- ☐ Fears

Family Concerns
- ☐ Intimacy
- ☐ Sexuality/Fertility
- ☐ Relationship with partner
- ☐ Relationship with children

Spiritual/Religious Concerns
- ☐ Relationship with God or Higher Power
- ☐ Loss of faith

Other concerns not listed above: _____

As a result of my Distress Screening, I would like information on:
- ☐ Counseling services
- ☐ Education/support groups
- ☐ Spiritual support
- ☐ Advance Directive (Designation of Healthcare Surrogate Form, Living Will Form)

_____	_____	_____	_____
Patient Signature	Print First and Last Name	Date	Time

_____ OR ☐ Phone ☐ Video	_____	_____	_____
Qualified Staff / Interpreter Signature (Check)	Print Qualified Staff / Interpreter Name	ID Number	Language Interpreted

Staff Use

I have reviewed the above information with the patient.

_____	_____	_____	_____
Social Worker Authentication Signature	Print First and Last Name	Date	Time

AdventHealth
Distress Screening
#66103 01-19-24

Clear Form Save Form

Patient Label