



There for you, every step of the way.

Dear Patient:

Welcome to Missouri Cancer Associates-George Rea Cancer Treatment Center! See enclosed appointment information with our facility in Kirksville, MO. Please arrive 30 minutes early for registration.

Please complete the enclosed forms and bring them with you to your appointment along with your insurance cards. **We will also need you to bring your current medication bottles to the appointment including prescription and over the counter medications. If you have completed an advanced directive for healthcare of any kind, please bring a copy of that as well.**

Instructions for the demographic form:

1. Please fill out each line of the form.
2. For the emergency contact, please list either a family member or friend that has a different phone number than you.
3. Sign and date the form on the second page.

Instructions for the Health Questionnaire:

1. Fill out all information regarding you and your family history.
2. Make sure and complete all pages.

Missouri Cancer Associates-George Rea has a knowledgeable and courteous Patient Benefit Representative who will verify your insurance benefits prior to your appointment. Co-pays, deductibles and/or co-insurance amounts are expected on the dates services are provided. Missouri Cancer Associates-George Rea does offer financial assistance for patients who are in need. Please contact your Patient Benefit Representative with questions.

Please note, there is a \$25 fee for all FMLA and disability forms requiring a physician/nurse to complete and sign.

Thank you for placing your trust in Missouri Cancer Associates-George Rea. If you have any questions or concerns, you may contact our office at 660-785-1050. You can also visit our website at [www.missouricancer.com](http://www.missouricancer.com). We look forward to meeting you.

Sincerely,

[www.missouricancer.com](http://www.missouricancer.com) | 1705 E. Broadway, Suite 100 | Columbia, MO 65201 | (866) 724-2413 | [Columbia@usoncology.com](mailto:Columbia@usoncology.com)  
George Rea Cancer Treatment Center | 603 W. Pierce | Kirksville, MO 63501 | (660) 785-1050 | [Kirksville@usoncology.com](mailto:Kirksville@usoncology.com)



Legal Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Marital Status (circle one): Single Married Divorced Separated Widow Other

Sex: Male Female Preferred Language \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity (circle one): Not Hispanic/Latino Hispanic/Latino

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_

Email \_\_\_\_\_

Preferred Contact Method (circle one): Home phone Cell phone Work phone Email

Employment Status (circle one): Employed Unemployed Retired Other

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Preferred Pharmacy Information**

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Policy Holder Information (complete if insurance is through spouse or parent)**

**Primary Insurance:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Insurance:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Employer \_\_\_\_\_

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**

I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Missouri Cancer Associates and Urology Associates of Central MO for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, responsible person(s) listed, Name of authorized person (specify relationship) or other healthcare providers assisting in my medical care.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I have been offered a copy of the Notice of Privacy Practices. We may share information through Carequality, a healthcare exchange, which is a provider portal for other providers involved in your care to have all the information necessary to diagnose and treat you.

**CONSENT TO TREATMENT:**

I authorize Missouri Cancer Associates/Urology Associates of Central MO and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of hepatitis A, B, C and HIV.

I understand that in order for Missouri Cancer Associates and Urology Associates of Central MO to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies. These transmissions are done in a safe manner that protects the privacy of personal information. I agree that Missouri Cancer Associates and Urology Associates of Central MO may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative.

**FINANCIAL AGREEMENT:**

I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered. I also understand and acknowledge that I am personally responsible to pay Missouri Cancer Associates and Urology Associates of Central MO in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have read and agreed to the provisions listed on this form and accept the terms. A duplicate of this statement is considered the same as original.

**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or DPOA (For patients 17 yrs of age or younger, parent or guardian MUST sign.)**

\_\_\_\_\_  
If legal representative, relationship to patient

**Emergency Contacts:**

**The patient above authorizes the disclosure of health and financial information to:**  
(This is not permission to release your official medical record)

**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_



There for you, every step of the way.

Dear Patient:

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Thank you for placing your trust in Missouri Cancer Associates. If you have any questions or concerns, you may contact our office at 573-874-7800 or toll free at 1-866-724-2413 and select "O" for the operator. You can also visit our website at [www.missouricancer.com](http://www.missouricancer.com). We look forward to meeting you.

Sincerely,

MO Cancer Associates Team



Legal Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Marital Status (circle one): Single Married Divorced Separated Widow Other

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Email \_\_\_\_\_

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Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Insurance:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Employer \_\_\_\_\_

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In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of hepatitis A, B, C and HIV.

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**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Patient or DPOA (For patients 17 yrs of age or younger, parent or guardian MUST sign.)**

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If legal representative, relationship to patient

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**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Names** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Missouri Cancer Associates  
Urology Associates of Central Missouri**

**NOTICE OF PRIVACY PRACTICES**

Effective Date: **September 23, 2013**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**About Us**

In this Notice, we use terms like “we,” “us,” “our” or "Practice" to refer to Missouri Cancer Associates, Urology Associates of Central Missouri, its physicians, employees, staff and other personnel. All of the sites and locations of Missouri Cancer Associates and Urology Associates of Central Missouri follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

**Purpose of this Notice**

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

**Our Responsibilities**

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

**How We May Use or Disclose Your Health Information**

**The following categories describe examples of the way we use and disclose health information without your written authorization:**

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information. We may also share information through Carequality, a healthcare exchange, which is a provider portal for other providers involved in your care to have all the information necessary to diagnose and treat you.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

**We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:**

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

### **Other Uses and Disclosures of Your Health Information that Require Written Authorization:**

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

## **Your Rights Regarding Your Health Information**

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to the office Privacy Officer. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the office Privacy Officer. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact staff at the front desk. You may also obtain a paper copy of this Notice at our website, [www.missouricancer.com](http://www.missouricancer.com).

## **Changes to this Notice**

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the scheduling area of our office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, [www.missouricancer.com](http://www.missouricancer.com).

## **Complaints**

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **Privacy Officer, 1705 E Broadway Ste 100 Columbia, MO 65201 or (573) 874-7800**. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

## **Questions**

If you have questions about this Notice, please contact the office Privacy Officer, (573) 874-7800.



# MISSOURI CANCER ASSOCIATES

*There for you, every step of the way.*

## Questions to Ask Your Physician

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Please write down any questions you may have regarding your diagnosis, your health, or anything you wish to discuss with the physician.

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

6. \_\_\_\_\_

\_\_\_\_\_

7. \_\_\_\_\_

\_\_\_\_\_

8. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_



**MISSOURI CANCER  
ASSOCIATES**

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## Health Questionnaire

### PAST MEDICAL HISTORY

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (✓) in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	Medical Problem	Surgery	Year(s) of Surgery	Describe
Eyes (cataracts, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, nose, sinuses, or tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid or parathyroid glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Coronary (heart) arteries (angina)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arteries (aorta, arteries to head, arms, legs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Veins or blood clots in the veins	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Esophagus or stomach (ulcer)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bowel (small & large intestine) or appendix	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver or gallbladder (including hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lymph nodes or spleen	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bones, joints or muscles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, neck or spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Females: uterus, tubes, ovaries	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Males: prostate, penis, testes, vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Patient Initials/Date of Birth: \_\_\_\_\_

**Female Patients Only:**

Have you ever taken birth control pills or hormone replacement?  No  Yes

Have you experienced menopause or had a hysterectomy?  No  Yes

If no: Are you concerned about your menstrual periods?  No  Yes

Might you be pregnant at this time?  No  Yes

Date of onset of your last menstrual period: mo: \_\_\_\_\_ yr: \_\_\_\_\_

Approximate date of your last Pap smear and pelvic exam: mo: \_\_\_\_\_ yr: \_\_\_\_\_  Never

Age at first menstrual period: \_\_\_\_\_ Age at first pregnancy: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Live births: \_\_\_\_\_

**PERSONAL HISTORY**

Have you ever had any of the following:	YES	Describe the problem when appropriate:
Anxiety, depression or mental illness	<input type="checkbox"/>	_____
Autoimmune disease (Lupus, Rheumatoid arthritis, etc.)	<input type="checkbox"/>	_____
Blood problems (abnormal bleeding or anemia)	<input type="checkbox"/>	_____
Blood or blood product transfusion	<input type="checkbox"/>	_____
Chemotherapy or immunotherapy	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Polyp or tumor removed from colon or rectum	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	_____
High cholesterol or triglycerides	<input type="checkbox"/>	_____
Radiation (Cobalt or radioactive implants) therapy	<input type="checkbox"/>	_____
Stroke or TIA	<input type="checkbox"/>	_____
Treatment of alcohol and/or drug abuse	<input type="checkbox"/>	_____
Tuberculosis or positive skin test for TB	<input type="checkbox"/>	_____

**MEDICATIONS**

Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications. **Please use a separate piece of paper if necessary.** If you keep your list of medications and wish to provide it separately, you may bring it with you and we will make a copy for your medical chart.

Name of Medication	Dose	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Initials/Date of Birth: \_\_\_\_\_

**ALLERGIES**

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? Please list below.

Name of Medication	Describe Allergic Reaction	Have you had an allergic reaction to:
_____	_____	Iodine or shellfish <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	Latex, rubber or adhesive tape <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	Bee or wasp stings <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects?

No  Yes, please explain → \_\_\_\_\_

List any food allergies \_\_\_\_\_  None

**REVIEW OF SYSTEMS**

Please circle any of the following which apply to you.

Category	Issues	No Problems
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	<input type="checkbox"/>
Skin	Itching, rash, mole change	<input type="checkbox"/>
Eyes	Vision change, cataracts, glaucoma	<input type="checkbox"/>
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	<input type="checkbox"/>
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	<input type="checkbox"/>
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	<input type="checkbox"/>
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	<input type="checkbox"/>
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	<input type="checkbox"/>
Breasts	Discharge, mass, pain, tenderness	<input type="checkbox"/>
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	<input type="checkbox"/>
Neurologic	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling, coordination, muscle strength/tone	<input type="checkbox"/>
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	<input type="checkbox"/>
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	<input type="checkbox"/>
Lymphatic	Enlargement, tenderness of lymph nodes	<input type="checkbox"/>
Hematologic	Bruising, bleeding, recurrent infections	<input type="checkbox"/>

Patient Initials/Date of Birth: \_\_\_\_\_

**FAMILY HISTORY**

Father  Alive (Age \_\_\_ )  Deceased (Age \_\_\_ ) Cause of death: \_\_\_\_\_  
 Mother  Alive (Age \_\_\_ )  Deceased (Age \_\_\_ ) Cause of death: \_\_\_\_\_  
 Brothers # \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
 Sisters # \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
 Sons # \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
 Daughters # \_\_\_\_\_ Medical Problems: \_\_\_\_\_

Please check below if any blood relative has had any of the following conditions and note which relatives affected.

- Diabetes  Kidney disease  Easy bleeding  
 Heart disease  Thyroid disease  Blood clots  
 Stroke  Autoimmune disease

Cancer type: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Age diagnosed: \_\_\_\_\_  
 Cancer type: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Age diagnosed: \_\_\_\_\_  
 Cancer type: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Age diagnosed: \_\_\_\_\_  
 Cancer type: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Age diagnosed: \_\_\_\_\_

Is there a history of the following cancers? Please circle:

Breast / Ovarian / Uterine / Colon / Prostate / Pancreatic / Melanoma

**SOCIAL HISTORY**

How many years of school have you completed? \_\_\_\_\_ Are you married?  No  Yes Do you live alone?  No  Yes

Your current employment status:  Employed  Retired  Unemployed

Current or previous occupation: \_\_\_\_\_

Are you disabled?  No  Yes, please explain → \_\_\_\_\_

Do you have a living will or advance directive for healthcare?  No  Yes

If you are unable to make your own medical decisions, who will do that for you? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Have you used any of the following substances?

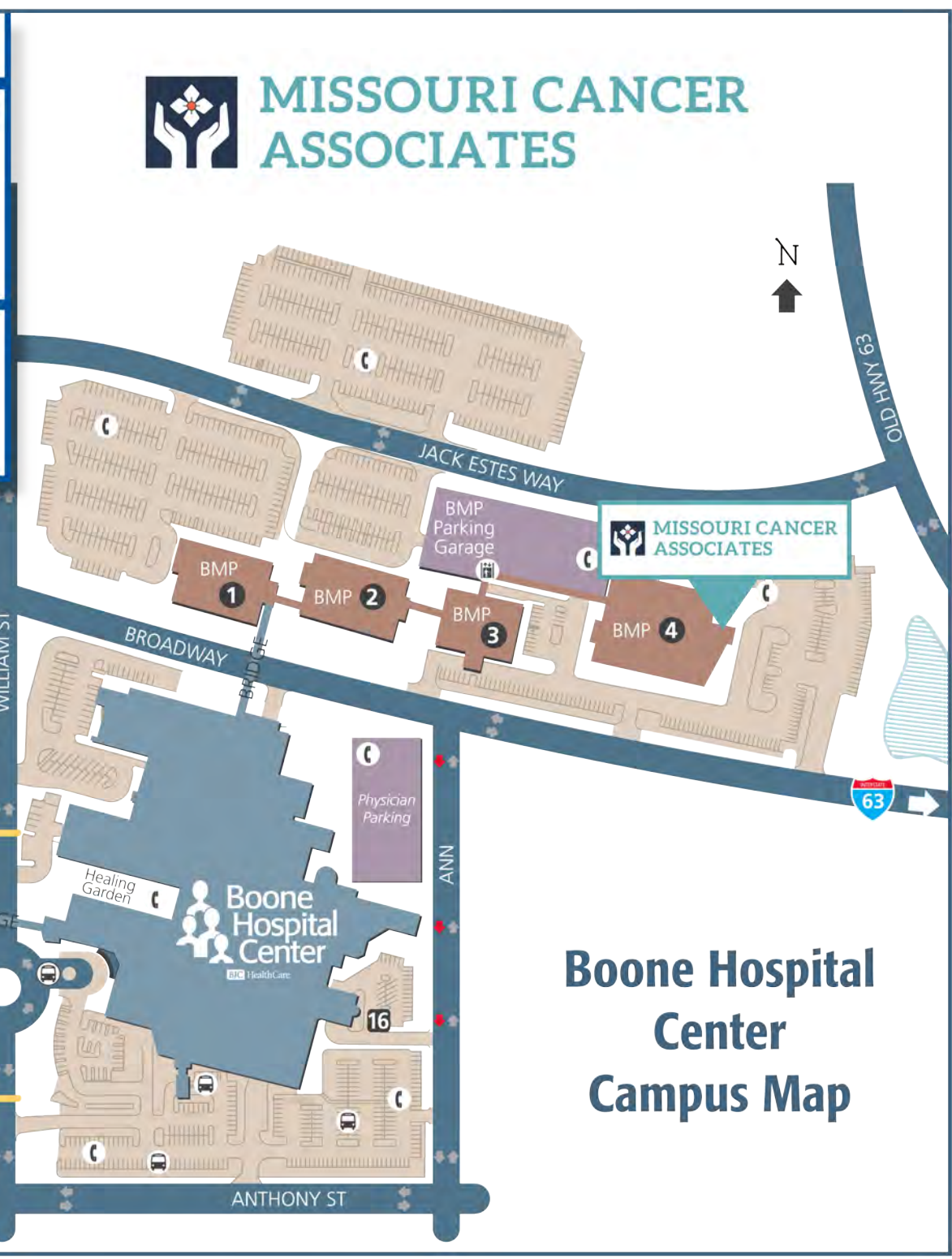
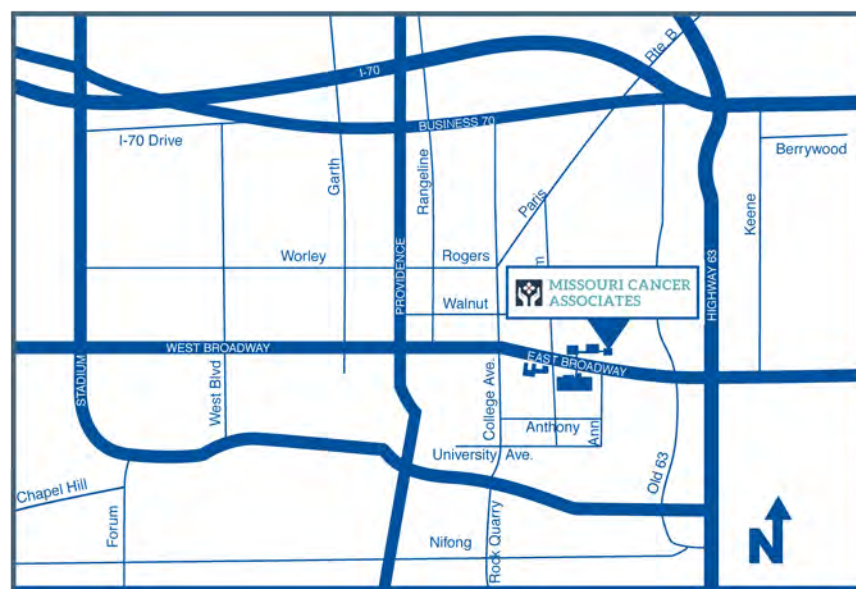
Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long (years)?	Year stopped?
Cigarettes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Alcohol (beer/wine)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Recreational/Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			

**Health Maintenance:** Please list the date of last exam and, if abnormal, any findings if known.

Last Mammogram	____/____/____	Location:
Last Colonoscopy	____/____/____	Location:
Last Bone Density Scan	____/____/____	Location:
Last Echocardiogram	____/____/____	Location:
Shingles vaccine	____/____/____	
Influenza vaccine	____/____/____	
Pneumovax vaccine	____/____/____	
COVID vaccine	____/____/____	Booster?



# MISSOURI CANCER ASSOCIATES



## Directions

From I-70, exit at Highway 63 South. Turn west on Broadway. Continue for approximately one mile to the first drive past Old Highway 63 on the right.

Our facility is located at:  
**1705 East Broadway**  
**Broadway Medical Plaza 4**  
**Suite 100**

Parking is available in front of the building.

Please feel free to call us at 573.874.7800 or toll-free at 866.724.2413.

## Boone Hospital Center Campus Map