HONORHEALTH

Virginia G. Piper Cancer Care Network

Welcome to the HonorHealth Virginia G. Piper Cancer Care Network.

We understand how challenging the diagnosis of a blood or bone marrow disorder can be and are committed to helping you every step of the way. Our valley-wide locations for hematology care, puts you, the patient, at the center of everything we do. We are here to support you and your family through diagnosis, treatment, and survivorship.

Because hematological disorders can have many different forms, our team of experts will provide you with extensive resources as a coordinated care team, all available within our network. These services may include:

- Imaging
- Laboratory
- Pathology
- Genetic counseling
- Surgery
- Patient navigation
- Mind, body and spirit programs
- Palliative care
- Nutritional support
- Social work services
- Clinical trials
- Interpreter services
- Symptom management
- Financial counseling
- Exercise physiology
- Physical, occupational and lymphedema therapy

The doctors, nurses and caregivers in the HonorHealth Virginia G. Piper Cancer Care Network look forward to providing you with outstanding hematologic care.

If you have questions, please do not hesitate to talk to your physician. You may also call 855-485-HOPE (4673) for additional medical hematology support.

It is an honor to serve you during this time.

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PATIENT REGISTRATION

Hematology/Medical Oncology and GYN Oncology Division

Patient Full Name: _____ **Birth Date:** _____

SSN: _____ **Email Address:** _____ **Gender**: ☐ M ☐ F

Home Address: _____ _____

Street City State Zip

Mailing Address: _____ _____

Street City State Zip

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

Mobile Phone: _____ **Mobile Phone Provider**: _____

Notification preference? ☐ Mobile Phone ☐ e-Mail ☐ Text Message ☐ Home Phone

May we leave a message (circle)? Yes or No **Please circle preference for voice message**: Home or Mobile Phone

Emergency Contact: _____ **Relationship to Patient**: _____

Home Phone: _____ **Mobile Phone**: _____

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino (requested demographic question for the State of AZ)

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ White/Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other: _____

Patient Employer: _____ **Occupation:** _____

Insurance Information

Primary Insurance: _____ **Subscriber Name**: _____

Subscriber Date of Birth: _____ **Relationship to Subscriber**: _____

ID# _____ **Group#:** _____

Secondary Insurance: _____ **Subscriber Name**: _____

Subscriber Date of Birth: _____ **Relationship to Subscriber**: _____

ID# _____ **Group#**: _____

Do you have a Living Will? ☐ Yes ☐ No **If yes, please provide a copy for our records**
Do you have a DNR? ☐ Yes ☐ No **If yes, please provide a copy for our records**

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PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Visit Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ When did the problem begin: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE #) _____

PRIMARY DOCTOR (NAME, ADDRESS, PHONE #) _____

PATIENT'S PHARMACY (NAME, ADDRESS, PHONE #) _____

MEDICINE/FOOD/LATEX/CONTRAST ALLERGIES:___ NONE or LIST IF ANY: _____

CURRENT MEDICATIONS (name and dosage) OR **CHECK HERE** _____ if Med List is attached

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CHRONIC CONDITIONS/PAST MEDICAL HISTORY: Have you ever had any of the following? (circle all that apply)

High Blood Pressure
Diabetes – If yes, type: _____
Stroke/TIA
Lupus
Heart Failure
Vascular Disease
Heart Disease
Heart attack
Seizures
Colitis/Diverticulitis
Abnormal Heart Rhythm
COPD
Hyperthyroidism
Heart Murmur
Neuropathy
Hypothyroidism
Aneurysm
Blood Clots
Genetic Disorder Type: _____
STDs - If yes, type: _____
HIV
Other: _____

Have you had any of the following tests?

	Yes	When and Where
Abnormal biopsy	☐	
CT Scan	☐	
MRI Scan	☐	
PET Scan	☐	
Mammogram	☐	
Colonoscopy	☐	
PAP Smear	☐	
Endoscopy	☐	
Blood Transfusions	☐	
Bone Mineral Density Test (DEXA	☐	

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PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Patient Name: _____ Date of Birth: _____

PATIENT SURGICAL HISTORY (NAME AND YEAR)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Any implanted devices or metal (pacemakers, pumps, etc.) Please circle: YES NO

VACCINES: Have you had the following vaccines:

PNEUMONIA ☐ NO ☐ YES, Date _____ **TETANUS** ☐ NO ☐ YES, Date _____

SHINGLES ☐ NO ☐ YES, Date _____ **FLU VACCINE** ☐ NO ☐ YES, Date _____

OTHER VACCINE ☐ NO ☐ YES, Date _____

TOBACCO USE: ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **ALCOHOL USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY

CAFFEINE (Coffee, tea, energy drinks) ☐ NEVER ☐ RARELY ☐ DAILY

DRUG USE: ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **EXPOSURE TO HIV:** ☐ NO ☐ YES

SOCIAL HISTORY: Lifestyle

Highest Education level: _____

With whom do you live? _____

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes, 3x/week or more

Have you experienced 10 lbs weight loss or gain in past 3 months? ☐ NO ☐ YES

SOCIAL HISTORY: Mobility

Do you have problems with mobility (use a wheelchair, cane, or walker)? ☐ NO ☐ YES; if yes describe issue and/or device used: _____

Have you had a fall in the past year? ☐ NO ☐ YES

Do you feel unsteady? ☐ NO ☐ YES

FAMILY MEDICAL HISTORY

	ALIVE AND WELL?	**DISEASE**	**IF DECEASED, CAUSE AND AGE OF DEATH**
FATHER	☐ NO ☐ YES	_____	_____
MOTHER	☐ NO ☐ YES	_____	_____

Are there any religious considerations that would keep you from receiving blood products? ☐ NO ☐ YES

Women only ---

Age menstrual cycle began: _____ **Menopause Age:** _____ **Number of Pregnancies:** _____ **Live Births:** _____

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Hematology/Medical Oncology and GYN Oncology Division

CONSTITUTIONAL SYMPTOMS		
ACTIVITY CHANGE	NO	YES
APPETITE CHANGE	NO	YES
CHILLS	NO	YES
DIAPHORESIS (SWEATING)	NO	YES
FATIGUE (WEAKNESS)	NO	YES
FEVER	NO	YES
NIGHT SWEATS	NO	YES
PAIN	NO	YES
RIGORS (CHILLS)	NO	YES
UNEXPECTED WEIGHT CHANGE	NO	YES
HEENT		
CONGESTION	NO	YES
DENTAL PROBLEM	NO	YES
DRY MOUTH	NO	YES
EAR PAIN	NO	YES
FACIAL SWELLING	NO	YES
HAIR LOSS	NO	YES
HEARING LOSS	NO	YES
MOUTH SORES	NO	YES
NOSEBLEEDS	NO	YES
POSTNASAL DRIP	NO	YES
RHINORRHEA (RUNNY NOSE)	NO	YES
SINUS PRESSURE	NO	YES
SORE THROAT	NO	YES
TASTE CHANGES	NO	YES
THRUSH	NO	YES
TINNITUS (RINGING IN EARS)	NO	YES
TROUBLE SWALLOWING	NO	YES
VOICE CHANGE	NO	YES
BREAST		
RIGHT INVERTED NIPPLE	NO	YES
RIGHT MASS	NO	YES
RIGHT NIPPLE DISCHARGE	NO	YES
RIGHT SKIN CHANGE	NO	YES
LEFT INVERTED NIPPLE	NO	YES
LEFT MASS	NO	YES
LEFT NIPPLE DISCHARGE	NO	YES
LEFT SKIN CHANGE	NO	YES
EYES		
BLURRED VISION	NO	YES
DOUBLE VISION	NO	YES
EYE DISCHARGE	NO	YES
EYE ITCHING	NO	YES
EYE PAIN	NO	YES

EYES CONTINUED		
EYE REDNESS (DRY EYES)	NO	YES
FLOATERS	NO	YES
PHOTOPHOBIA (SENSITIVITY TO LIGHT)	NO	YES
VISUAL DISTURBANCE	NO	YES
RESPIRATORY		
DYSPNEA ON EXERTION (SHORTNESS OF BREATH ON EXERTION)	NO	YES
CHEST TIGHTNESS	NO	YES
CHOKING	NO	YES
COUGH	NO	YES
HEMOPTYSIS(COUGHING UP BLOOD)	NO	YES
SHORTNESS OF BREATH (DIFFICULTY BREATHING)	NO	YES
STRIDOR	NO	YES
WHEEZING (ASTHMA)	NO	YES
CARDIOVASCULAR		
CHEST PAIN	NO	YES
LEG SWELLING	NO	YES
ORTHOPNEA	NO	YES
PALPITATIONS	NO	YES
PND(PAROXYSMAL NOCTURNAL DYSPNEA)	NO	YES
GI		
ABDONIMAL DISTENTION	NO	YES
ABDOMINAL PAIN	NO	YES
ANAL BLEEDING	NO	YES
ASCITES (ABDOMINAL SWELLING)	NO	YES
BLOOD IN STOOL (BLACK STOOLS)	NO	YES
CONSTIPATION	NO	YES
DIARRHEA	NO	YES
EARLY SATIETY (FEELING FULL)	NO	YES
GERD/HEARTBURN	NO	YES
NAUSEA AND VOMITING	NO	YES
HERNIA	NO	YES
ENDOCRINE		
COLD INTOLERANCE	NO	YES
DIABETES	NO	YES
HEAT INTOLERANCE	NO	YES
HOT FLASHES	NO	YES
POLYDIPSIA (GREAT THIRST)	NO	YES
POLYPHAGIA (EXCESSIVE EATING)	NO	YES
POLYURIA (EXCESSIVE URINATION)	NO	YES
PRE-DIABETES	NO	YES
GU		
DYSURIA((PAIN/DIFFICULTY URINATING, HESITANCY)	NO	YES
FLANK PAIN	NO	YES

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GU CONTINUED				PSYCHIATRIC		
FREQUENT URINATION	NO	YES		AGITATION	NO	YES
HEMATURIA (BLOOD IN URINE)	NO	YES		BEHAVIOR PROBLEM	NO	YES
INCONTINENCE	NO	YES		CONFUSION	NO	YES
NOCTURIA (FREQUENT URINATION AT NIGHT)	NO	YES		DECREASED CONCENTRATION	NO	YES
PENILE DISCHARGE	NO	YES		DEPRESSION	NO	YES
PENILE PAIN	NO	YES		HALLUCINATIONS	NO	YES
PENILE SWELLING	NO	YES		HYPERACTIVE	NO	YES
SCROTAL SWELLING	NO	YES		NERVOUS/ANXIOUS (PANIC ATTACKS)	NO	YES
TESTICULAR PAIN	NO	YES		SELF-INJURY	NO	YES
URGENCY TO URINATE	NO	YES		SLEEP DISTURBANCE (INSOMNIA)	NO	YES
DECREASED URINE	NO	YES		SUICIDAL IDEAS	NO	YES
MUSCULOSKELETAL				HOMICIDAL IDEAS	NO	YES
ARTHRALGIAS (JOINT PAIN/BONE PAIN)	NO	YES				
BACK PAIN	NO	YES				
GAIT PROBLEM (WALKING ABNORMALLY)	NO	YES				
JOINT SWELLING	NO	YES				
MYALGIAS (MUSCLE PAIN)	NO	YES				
NECK PAIN	NO	YES				
NECK STIFFNESS	NO	YES				
SKIN						
BLISTERING	NO	YES				
CHANGING MOLES (SKIN LESIONS)	NO	YES				
COLOR CHANGE	NO	YES				
ALLERGY/IMMUNE SYSTEM						
ENVIRONMENTAL/SEASONAL ALLERGIES	NO	YES				
FOOD ALLERGIES	NO	YES				
IMMUNOCOMPROMISED	NO	YES				
CHEMICALS IN WORKPLACE	NO	YES				
NEUROLOGICAL						
PAINFUL NEUROPATHY	NO	YES				
DIZZINESS	NO	YES				
FACIAL ASYMMETRY	NO	YES				
HEADACHES	NO	YES				
LIGHT-HEADEDNESS	NO	YES				
NUMBNESS/TINGLING	NO	YES				
SEIZURES	NO	YES				
SPEECH DIFFICULTY	NO	YES				
SYNCOPE (ALTERED CONSCIOUSNESS)	NO	YES				
TREMORS	NO	YES				
WEAKNESS (PARALYSIS)	NO	YES				
HEMATOLOGIC						
ADENOPATHY (ENLARGED GLANDS)	NO	YES				
BRUISES/BLEEDS EASILY	NO	YES				
LYMPHEDEMA	NO	YES				
PETECHIAE (BLEEDING UNDER SKIN)	NO	YES				
PURPURA (RASH)	NO	YES				

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HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Healthcare Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and 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 and Great Grandchildren*

YOU and 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*	45	——	—	Aunt Cousin	45 51	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 GASTROINTESTINAL POLYPS *(Specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	*Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ 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 generic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o **2 or more:** breast / ovarian / prostate / pancreatic cancer o **2 or more:** colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o **2 or more:** melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger:**	o Breast cancer o Colorectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age:**	o Ovarian cancer o Breast: Male breast cancer or Triple negative breast cancer o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† o Endometrial cancer with abnormal MSI/IHC o 10 or more gastrointestinal polyps*

†† Presence of tumor infiltrating lymphocytes, Chrohn's-lick lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern * Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment _____

HONORHEALTH®
Virginia G. Piper
Cancer Care Network

Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends with whom Virginia G. Piper Cancer Care Network can share your protected health information.

Name	Phone Number	Relationship

I _____ acknowledge that I have received a copy of Virginia G. Piper Cancer Care Network's Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Virginia G. Piper Cancer Care Network.
I understand that this release is valid for the time frame of my diagnosis, but may revoke authorization at any time by informing Virginia G. Piper Cancer Care Network specialists and my physician.

Print Name: _____ Date: _____

Patient Signature: _____