ONCURA HEALTH

Date: _____

NEW PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

Office | Date

Last Name | First Name | Nickname

Date of Birth | Sex | Last 4 Digits SSN (Optional) | Address

Apt/Suite | City | State/Zip | Home Phone

Email | Mobile Phone

Primary Provider | Referring Provider

Employer | Work Phone | Marital Status

Is your spouse working or retired? | Spouse Name | Spouse DOB

Spouse SSN | Spouse Phone | Alternative Address

Apt/Suite | City | State | ZIP

INSURANCE INFORMATION

Primary Insurance | Plan ID | Group #

Phone Number | Policy Holder | Policy Holder DOB

Secondary Insurance | Plan ID | Group #

Phone Number | Policy Holder | Policy Holder DOB

Guarantor | Guarantor Relationship

EMERGENCY CONTACT INFORMATION

Name | Phone Number | Relationship

Address | Apt/Suite | City | State | ZIP

ONCURA HEALTH

Date: _____

HOSPITAL / HOSPICE / SKILLED NURSING FACILITY

Are you currently admitted to a hospital or enrolled in a hospice or skilled nursing facility? ○ Yes ○ No If yes, please fill out the following:

Facility Name **Phone Number** **Address**

Apt/Suite **City** **State** **ZIP**

VETERANS ADMINISTRATION BENEFITS

Are you receiving benefits from the Veterans Administration? ○ Yes ☐ No If yes, please fill out the following:

VA Name **Phone Number** **Address**

Apt/Suite **City** **State** **ZIP**

Providing the information in the following sections is voluntary and is used to support quality of care, patient safety, language access and comply with non-discrimination.

Sex Assigned at Birth (Choose 1)	
☐ Male	☐ Female
☐ Intersex	☐ Other
☐ Decline to Disclose	

Gender Identity		
☐ Male	☐ Female	☐ Non-Binary
☐ Trans-Male	☐ Trans-Female	☐ Decline to Disclose

Which of the following best describes your race and/or ethnicity? (Select all that apply)			
☐ Asian	☐ Caucasian	☐ Black/African American	☐ Middle Eastern/North African
☐ Hispanic	☐ Native Hawaiian/Pacific Islander	☐ American Indian/Alaskan Native	☐ Choose Not to Disclose

What language do you feel most comfortable using when discussing your healthcare?					
☐ English	☐ Spanish	☐ German	☐ French	☐ Italian	☐ Russian
☐ Portuguese	☐ Chinese	☐ Creole	☐ Other	☐ Decline	

SOCIAL HISTORY

Have you ever smoked? ○Yes ○ No If yes, packs per day: For how many years:

Have you quit smoking? ○Yes ○ No If yes, what year did you quit?

Have you ever chewed tobacco? ○Yes ○ No If yes, how much and how often?

Have you quit chewing tobacco? ○Yes ○ No If yes, what year did you quit?

ONCURA HEALTH

Date: _____

Have you ever attended tobacco cessation classes? ○ Yes ○ No — If yes, when? _____

Do you drink alcohol? ○ Yes ○ No — If yes, how much and how often? _____

Have you quit drinking? ○ Yes ○ No — If yes, what year did you quit? _____

Do you use any street drugs? ○ Yes ○ No — If so, which: ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Other

Do you have a medical marijuana card? ○ Yes ○ No

Do you need any help with any of the following: coping, financial assistance, nutrition, social work, transportation, home assistance? ○ Yes ○ No
(This information helps us connect you with support services and is optional.)

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Do you have a strong social support system? ○ Yes ○ No — If so, who? _____

Do you have any religious or cultural beliefs that may affect your medical care? ○ Yes ○ No — If yes, explain: _____

Certain types of sensitive health information — including records related to HIV/AIDS, mental health, substance abuse disorder treatment, genetic testing, and reproductive health — may be subject to additional protections under applicable California and federal law and will only be disclosed as permitted or required by law.

Are you still working? ○ Yes ○ No
If yes: ☐ Full-Time ☐ Part-Time
If no: ☐ Retired ☐ Disabled ☐ Unemployed

What is or was your primary occupation? _____

Did you ever work in an occupation involving exposure to asbestos, carcinogens, hazardous chemicals, or toxic fumes? ○ Yes ○ No

Have you ever served in the military? ○ Yes ○ No — If yes, which branch? _____

MOBILITY & FALL RISK ASSESSMENT

Do you need assistance walking? If so, do you use any of the following? ○ Yes ○ No ☐ Cane ☐ Walker ☐ Wheelchair

Have you fallen before or been injured because of a fall? ○ Yes ○ No

ONCURA HEALTH

Date: _____

Do you have foot ulcers, bunions, hammertoes, or calluses that are painful or cause you to adjust your steps while walking? ○ Yes ○ No

Do you feel unsteady on your feet or shuffle when you walk? ○ Yes ○ No

Do you feel dizzy/lightheaded when you stand up? ○ Yes ○ No

How many falls in the past 12 months? _____ Any injuries? _____

We screen all patients for domestic violence or abuse. Disclosure is confidential and assistance resources are available upon request.

Does anyone at home hurt, hit, or threaten you? ○ Yes ○ No If yes, explain: _____

SOCIAL GEOGRAPHIC HISTORY

In which state (or country) were you born? _____ **In what area did you live most of your life?** _____

How long have you lived in your current state of residence? _____ **Do you live here all year round?** ○ **Yes** ○ **No**

If no, what is your alternate address and phone number? _____

Are you allergic to latex? ○ Yes ○ No If yes, reaction: _____

Are you allergic to IV Contrast? ○ Yes ○ No If yes, reaction: _____

Are you allergic to any medications? ○ Yes ○ No If yes, list all: _____

Other allergies (drug, food, tape, etc.)? _____

CURRENT MEDICATIONS

Medication	Dose	Frequency	Route	Prescribing Physician

ONCURA HEALTH

Date: _____

Pharmacy Name **Pharmacy Phone**

RADIATION THERAPY, CHEMOTHERAPY & HORMONE THERAPY HISTORY

Have you ever received radiation therapy? ○ Yes ○ No — What part of the body/area was treated?

Have you ever received chemotherapy? ○ Yes ○ No — If yes, when?

Have you ever received hormone therapy? ○ Yes ○ No — If yes, when? Which medication?

PAST MEDICAL HISTORY (Check all that apply)

☐ Cancer Diagnosis If so, what type?	☐ Heart Disease/CAD	☐ Emphysema	☐ Diabetes
☐ Heart Attack	☐ COPD	☐ Thyroid Disorder	☐ Congestive Heart Failure
☐ Pneumonia	☐ Kidney Disease	☐ Atrial Fibrillation	☐ Chronic Bronchitis
☐ Liver Disease	☐ High Cholesterol	☐ Asthma	☐ HIV
☐ Hypertension	☐ Stroke	☐ Anemia	☐ Other

REVIEW OF SYSTEMS (Check all that apply)

Constitutional	Pulmonary	Psychiatric	Genitourinary
☐ Fever/Chills	☐ Persistent Cough	☐ Anxiety	☐ Difficulty Starting Stream
☐ Increased Fatigue	☐ Coughing Up Blood	☐ Depression	☐ Stopping and Starting Stream
☐ Night Sweats	☐ Shortness of Breath	☐ Psychosis	☐ Blood in Urine
☐ Unexplained Weight Loss	☐ Inability to Lie Flat	☐ Bipolar Disorder	☐ Pain or Burning on Urination
☐ Weight Gain	☐ Positive TB Test (Date: _____)		☐ Frequent Urination
	☐ Influenza Vaccine (Date: _____)		☐ Getting Up at Night to Urinate
	☐ Pneumonia Vaccine (Date: _____)		☐ Urinary Urgency
	☐ COVID-19 Vaccine (Date: _____)		☐ Leakage of Urine
			☐ Kidney Stone
			☐ Elevated PSA
			☐ Urinary Tract Infections
			☐ Difficulty with Erections
			☐ Are you sexually active?

Current Height	Current Weight	Influenza Vaccine	Pneumonia Vaccine	COVID-19 Vaccine
		Date: _____	Date: _____	Date: _____

Date: _____

Eyes/Ears/Nose/Throat	Rheumatological	Gastrointestinal	Neurological/Cardiac
☐ Cataracts	☐ Systemic Lupus Erythematosus	☐ Difficulty Swallowing	☐ Frequent Headaches
☐ Glaucoma	☐ Rheumatoid Arthritis	☐ Decreased Appetite	☐ Dizziness/Lightheadedness
☐ Diminished Eyesight	☐ Osteoarthritis/Arthritis	☐ Frequent Vomiting	☐ Tremors
☐ Experienced Hearing Loss	☐ Scleroderma/CREST Syndrome	☐ Hiatal Hernia	☐ Paralysis
☐ Sinus Problems	☐ Gout	☐ Gastric Reflux	☐ Numbness
☐ Hoarseness	☐ Bone Pain	☐ Bowel Polyps	☐ Polio
☐ Dentures	☐ Broken Bones	☐ Dark/Black Stool	☐ Weakness in Limbs
		☐ Blood in Stool	☐ Seizures
		☐ Frequent Diarrhea	☐ Angina (chest pain)
		☐ Inflammatory Bowel Disease (Ulcerative Colitis/Crohn's)	☐ Irregular Heartbeat
		☐ Constipation	
		☐ Hemorrhoids ☐ Diverticulosis / Diverticulitis	
		☐ Colonoscopy/Sigmoidoscopy (Date: _____) Yes / No	

PAST SURGICAL HISTORY (Please list year in the box)

☐ Eye Surgery	Year:	☐ Appendectomy	Year:	☐ Tonsillectomy	Year:	☐ Cholecystectomy	Year:
☐ Coronary Artery By-Pass	Year:	☐ Heart Valve Replace/Repair	Year:	☐ Coronary Artery Stent	Year:	☐ Defibrillator Placement	Year:
☐ Pacemaker Placement	Year:	☐ Colon or Rectal Surgery	Year:	☐ Bladder Surgery	Year:	☐ Thyroid Surgery	Year:
☐ Lung Surgery	Year:	☐ Breast Surgery	Year:	☐ Hernia Surgery	Year:	☐ D & C	Year:
☐ Heart Surgery	Year:	☐ Prostate Surgery	Year:	☐ Hysterectomy or Gynecological Surgery	Year:	☐ Joint Replacement	Year:
☐ Other	Year:						

ONCURA HEALTH

Date: _____

FEMALE HISTORY

Please complete the following if you are female (or if applicable based on your anatomy or clinical history).

Age 1st Menstrual Period | **Last Menstrual Period** | **Age of Menopause** | **Any chance you could be pregnant? ○ Yes ○ No**

Number of Pregnancies | **Number of Deliveries** | **Age 1st Child Was Born** | **Did you breastfeed? ○ Yes ○ No**

Did you ever take hormones (estrogen, birth control pills, androgens, etc.)? ○ Yes ○ No | **If yes, how long?**

Bra Cup Size | **Nipple Discharge** | **Vaginal Bleeding** | **Vaginal Discharge** | **Hx of STDs ○ Yes ○ No**

Date of Last PAP Smear | **Date of Last Mammogram**

MALE HISTORY

Please complete the following if you are male (or if applicable based on your anatomy or clinical history).

Date of Last PSA | **Score of Last PSA** | **Where** | **Hx of STDs ○ Yes ○ No**

PAIN

PAIN MEASUREMENT SCALE

0 = No Pain → 10 = Worst Pain Imaginable

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

Quality: ○ Sharp ○ Dull ○ Constant ○ Intermittent ○ Cramping ○ Aching ○ Stabbing

PAIN MANAGEMENT QUESTIONS

Are you in pain now? Yes ○ No ○

When did your pain start?

Location of Pain:

How long have you been in pain?

How is your pain being managed?

Anything making it better?

Anything making it worse?

FAMILY HISTORY OF CANCER OR BLOOD DISEASES

Father	Mother	Siblings	Children
If living, age	If living, age	How many sisters?	How many daughters?
		How many brothers?	How many sons?
If deceased, age of death	If deceased, age of death		
Any history of cancer?	Any history of cancer?	Any history of cancer?	Any history of cancer?
Type	Type	Type	Type

Is there any history of cancer or blood diseases in other family members (grandparents, aunts, uncles, cousins, etc.)? ○ Yes ○ No

If yes, please explain:

Date: _____

PHYSICIAN CORRESPONDENCE

Please list the names and addresses of physicians you would like correspondence sent to.

Name	Address	Phone

ADVANCE DIRECTIVES

Advance Care Planning (ACP) is an ongoing process of learning about the choices we have for our future medical care. An advance directive is optional and not required to receive treatment. Information about advance directives is available upon request.

Do you have any of the following? (Check all that apply)

☐ Healthcare Proxy ☐ Medical Power of Attorney ☐ Living Will ☐ Do Not Resuscitate (DNR)

☐ Organ Donor Card ☐ Power of Attorney ☐ POLST / Advance Directive (California)

Would you like more information about Advance Care Planning? ○ Yes ○ No

If you answered "yes" to any of the above, please provide a copy of the document to staff at check-in.

PATIENT CERTIFICATION & SIGNATURE

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient / Patient Representative Signature: Date: