MRN______________________

275 Dry Hill Rd.
Beckley, WV 25801
(304) 253-6060 or
(304) 253-6080
FAX (304) 253-6086

CAMC Cancer Center

Charleston Area Medical Center
Vandalia Health

Beckley

PATIENT REGISTRATION

PATIENT'S NAME: ____

MAILING ADDRESS: ____

CITY: ______________ STATE ________ ZIP __________ COUNTY: ______________

SOCIAL SECURITY NO: ______________________ DATE OF BIRTH: ______________

HOME PHONE: ______________________ CELL PHONE: ______________________

ALTERNATE PHONE: ______________

MARITAL STATUS: ❏ SINGLE ❏ MARRIED ❏ DIVORCED ❏ WIDOWED ❏ LEGALLY SEPERATED

GENDER: ❏ MALE ❏ FEMALE RACE: ______________________________

IF MARRIED SPOUSE'S NAME: ______________________________

ARE YOU EMPLOYED? ❏ YES ❏ NO IF YES, WHERE: ______________________

PRIMARY CARE PHYSICIAN: ______________________________

REFERRING PHYSICIAN: ______________________________

EMAIL ADDRESS: ______________________________

WOULD YOU LIKE ACCESS TO OUR PATIENT PORTAL? ❏ YES ❏ NO (MUST HAVE EMAIL ADDRESS)

EMERGENCY CONTACT *** MUST BE LISTED ON YOUR HIPAA FORM ***

NAME: ______________________________ PHONE: ______________________

RELATIONSHIP TO PATIENT: ______________________________

DO YOU HAVE ANY ADVANCE DIRECTIVES? ❏ YES ❏ NO ❏ LIVING WILL ❏ MEDICAL POWER OF ATTORNEY

IF NO, WOULD YOU LIKE TO SPEAK TO SOMEONE CONCERNING ADVANCE DIRECTIVES? ❏ YES ❏ NO

IF YES, PLEASE PROVIDE OUR OFFICE WITH COPIES.

PLEASE PROVIDE INSURANCE CARD AND PICTURE ID TO REGISTRATION!

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PATIENT CONSENT FORM

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care operations. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent. You have the right to a paper copy of this Notice at any time. You may obtain a copy of this Notice from us or at www.clcancercenter.com.

The terms of our notice may change. We will post a copy of the current notice in our facility. At any time, you may request a copy of our current notice in effect.

You have the right to request that we restrict how protected health information about you is used or disclosed for health care treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by those restrictions to which we agree.

By signing this form, you consent to our use and disclosure of protected health information about you for health care treatment, payment, and health care operations, and you acknowledge that you have access to receive a copy of our Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent.

Patient/Personal Representative: ____

Date: ____

STAMP OR WRITE

NAME: AGE:

PATIENT HISTORY

PAST HISTORY: Check if you have had and what year

	Yes	Year
1. Measles		
2. Mumps		
3. Whooping Cough		
4. Polio		
5. Scarlet Fever		
6. Diptheria		
7. Meningitis		
8. Infectious Mono		
9. Valley Fever		
10. Malaria		
11. Bladder Infections		
12. Rheumatic Fever		
13. Hives		
14. Hay Fever/Sinusitis		
15. Asthma		
16. Emphysema		
17. Tuberculosis		
18. Exposure to TB		
19. Bronchitis		
20. Pneumonia		
21. Pleursy		
22. Hepatitis (Yellow Jaundice)		
23. Heart Disease		
24. High Blood Pressure		
25. Kidney Disease		
26. Bleeding Tendency		
27. Anemia		
28. Ulcer		
29. Hemorroids		
30. Arthritis		
31. Back Trouble		
32. Blood Transfusion		
33. Cancer		
34. Diabetes		
35. Other Chronic Problems		
36. Clots Leg - DVT's		

OPERATIONS: Check if yes and what year

	Yes	Year
Tonsils		
Appendix		
Gall Bladder		
Stomach		
Breast		
Uterus and/or Ovary		
Prostate Hernia		
Thyroid		
Varicose Veins		
Hemorrhoids		
Heart		
C-Section		
Tubal Ligation/Vasectomy		
Other		

INJURIES / Hospitalizations:
Check if yes and what year:

	Yes	Year
Head		
Chest		
Abdomen		
Broken Bones		
Back		
Any other hospitalizations not mentioned before		

IMMUNIZATIONS:
Check if yes.

	Yes	Last Date
Smallpox		
Tetanus		
Polio Shots		
Polio Oral		
Pneumonia		
Hepatitis		
Other		

PERSONAL HISTORY:

Birthplace ______

Nationality ______

Marital Status ______

Who lives in your household with you? ______

Employment at Present ______

Previous Occupations ______

Residence Past 5 years ______

Education Through ______ Grade

Type of Home ______

Habits: Sleep ______ Hours Per Night

Temperament ______

Recreation ______

Exercise ______

Average Per Day:

Alcohol (type) ______

Tobacco (type) ______

Tea Coffee ______

Sexually Active ______

Number of Partners Last Year ______

History of any Sexually Transmitted Diseases (i.e. herpes, genital warts, syphilis, gonorhea) ______

Have you ever abused drugs:

Alcohol ______

Cocaine ______

IV Drugs ______

Marijuana ______

Others ______

FAMILY HISTORY: Has any blood relatives had any of the following?
Check yes and what relationship.

	Yes	Relationship
1. Anemia		
2. Bleeding Tendency		
3. Leukemia		
4. Heart Disease		
5. High Blood Pressure		
6. Chronic Lung Disease		
7. Asthma		
8. Tuberculosis		
9. Severe Allergies		
10. Repeated Infections		
11. Obesity		
12. Peptic Ulcer		
13. Chronic Diarrhea		
14. Diabetes		
15. Gout		
16. Kidney Disease		
17. Crippling Arthritis		
18. Thyroid Disease		
19. Mental Illness		
20. Convulsions or Fits		
21. Migraine Headaches		
22. Cancer		

	Present Age or Age at Death	If Living, health (good, fair, poor) If Deceased, Cause of Death
Father		
Mother		
Brothers or Sisters		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

REVIEW OF SYSTEMS. Check yes if you have now or have had in the past month.

		Yes
1)	**General**	
	Tire Easily, Weakness	______
	Marked Weight Change	______
	Night Sweats	______
	Persistent Fever	______
	Sensitivity to Heat	______
	Sensitivity to Cold	______
	Change in any Skin Lesions	______
2)	**Eyes**	
	Trouble Seeing	______
	Eye Pain	______
	Inflamed Eyes	______
	Double Vision	______
	Wear Glasses	______
	Contacts	______
3)	**Ears**	
	Loss of Hearing	______
	Ringing in Ears	______
	Discharge	______
4)	**Nose**	
	Loss of Smell	______
	Frequent Colds	______
	Obstruction	______
	Excess Discharge	______
	Nosebleeds	______
5)	**Mouth**	
	Sore Gums	______
	Soreness of Tongue	______
	Dental Problems	______
	False Teeth	______
	Bleeding Gums	______
6)	**Throat**	
	Postnasal Drainage	______
	Soreness	______
	Hoarseness	______
7)	**Cardiovascular/Respiratory**	
	Cough, Persisting	______
	Sputum (Phlegm)	______
	Bloody Sputum	______
	Wheezing	______
	Chest Pain or Discomfort	______
	Pain on Breathing	______
	Shortness of Breath	______
	Difficulty Breathing While Lying Down	______
	Swelling of Ankles	______
	Bluish Fingers or Lips	______
	Palpitations	______
	Vein Trouble	______
8)	**Gastrointestinal**	
	Change in Appetite	______
	Difficulty Swallowing	______
	Heartburn	______
	Abdominal Pain	______
	Belching or Excess Gas	______
	Abdominal Enlargement	______
	Nausea	______
	Vomiting	______
	Vomiting of Blood	______
	Rectal Bleeding	______
	Black Tarry Stools	______
	Jaundice	______
	Diarrhea	______
	Constipation	______
	Need for Laxatives	______

(Patient's) Signature:______________________________

Date:______________________

		Yes
9)	**Genitourinary System**	
	Increase in Frequency of Urination (day)	______
	Increase in Frequency of Urination (night)	______
	How Many times a night?)__________	
	Feel Need to Urinate Without Much Urine	______
	Unable to Hold Urine	______
	Pain or Burning on Urination	______
	Blood in Urine	______
	Lack of Sex Drive	______
	(How Long?)________	
10)	**Musculoskeletal**	
	Muscle Cramps	______
	Muscle Weakness	______
	Pain in Joints	______
	Swollen Joints	______
	Stiffness	______
	Deformity of Joints	______
11)	**Breast**	
	Lumps	______
	Discharge	______
	Pain (when)______________________________	
12)	**Skin**	
	Eruptions (rash)	______
	Change in Color	______
	Change in Hair	______
	Change in Nails	______
	Change in Any Skin Lesions	______
13)	**Nervous System / Psychiatric**	
	Headaches	______
	Dizziness	______
	Fainting	______
	Convulsions or Fits	______
	Nervousness	______
	Sleeplessness	______
	Depression	______
	Change in Sensation	______
	Memory Loss	______
	Poor Coordination	______
	Weakness or Paralysis of Muscles	______
14)	**Endocrine**	
	Thyroid Trouble	______
	Adrenal Trouble	______
	Cortisone / Steroid Treatment	______
15)	**Hematologic / Lymphetic**	
	Swollen Lymph Nodes	______
	Platelet Problem	______
	Excessive Bleeding	______
16)	**Allergic / Immunologic**	
	Are you allergic to:	
	Foods	______
	Types______________________________	
	Cosmetics	______
	Betadine	______
	Tape	______
	Dust	______
	Pollen	______
	Animals	______
	Others (not drugs)	______
	List______________________________	

GYN - OB

Started menstruating at age________ Date of last Period________________

Interval between periods__________days Duration______________days

Flow Light Normal Heavy

Pain with periods Yes____ No_____ Duration____________________

Number of Pregnancies____________ Number of Miscarriages____________

Number of births________ Weight of babies at birth________________