SILICON VALLEY ONCOLOGY | The US Oncology Network

RIZWAN NURANI, MD

PAST MEDICAL AND SURGICAL HISTORY (please use black ink)	Today's Date:	

Patient Name (Last, First, MI)	Date of Birth (mm/dd/yy)	Age

Primary Care Physician	Address	Telephone/Fax
		( ) ( )
Pharmacy	**Address**	**Telephone**
		( )

SERIOUS MEDICAL ILLNESSES

Please Check All That Apply

PACEMAKER ☐ NO ☐ YES		**Note**			
Heart Attack				**X**	**Note**
Heart Failure			Diabetes		
Angina			If yes, do you use insulin?		
High cholesterol			Cancer		
High blood pressure			If yes, what type?		
Heart valve problem			Joint replacement		
Chronic lung disease			Bleeding disorder		
Asthma			Peptic Ulcer		
Kidney failure			Thyroid problems		
Incontinence / Bladder Control			Neurological/Psychiatric problems		
Have you ever had a Pneumonia Vaccine? ☐ Yes ☐ No Colonoscopy ☐ Yes ☐ No Year _____			Flu Shot ☐ No ☐ Yes (Month/Year Administered)		

OTHER/DETAILS:

Patient Name *(Last, First, MI)*	**Date of Birth (mm/dd/yy)**

PAST SURGICAL HISTORY

☐ **I have reviewed this information and I have no past surgical history to report.**

YEAR	TYPE	YEAR	TYPE

MEDICATIONS (Please write full dosages)

Please list all prescriptions and over-the-counter medications, including vitamins and herbs that you are taking.

Name of Medication:	Frequency:	Dose:

HORMONE INJECTIONS: ☐ Name: _____ ☐ Duration_____ ☐ None

Do you use any nitroglycerin medications (medicine for chest pain?) ☐ Yes ☐ No

ALLERGIES TO MEDICATIONS? If yes, which medications are you allergic?: *Please list in boxes below*

		☐ **No known allergies to any medications**	

FAMILY HISTORY

Any immediate family member diagnosed with cancer? If so please indicate below:

	X	Type of Cancer	Age at diagnosis
Father			
Mother			
Sibling		Circle: Sister/Brother	
Paternal Grandparent		Circle: Grandmother/Grandfather	
Maternal Grandparent		Circle: Grandmother/Grandfather	
Children		Circle: Son/Daughter	

SOCIAL HISTORY

	No	Yes	Frequency / Amount	When did you start?	When did you stop?
Substances					
Tobacco					
Alcohol					
☐ **Beer** ☐ **Liquor** ☐ **Wine** ☐ **None**					
			How many cups/day		
Coffee					
Tea					
Soft Drinks w/ caffeine					

Patient Name (Last, First, MI)	**Date of Birth** (mm/dd/yy)

REVIEW OF SYMPTOMS

Please check all symptoms that you are having right now.

	X	NOTE		X	NOTE
GENERAL			**HEAD/EYES/EARS/NOSE/THROAT**		
Weight loss			Headaches/Migranes		
Loss of appetite			Hearing Problems		
Night Sweats			Ringing in Ears		
Fatigue			Nasal congestion		
Nausea			Eye pain		
Fever			Dental problems		
Chills			Dry Mouth		
No Problems			Difficulty swallowing		
RESPIRATORY			Vision problems		
Cough			Sore Throat		
Phlegm			No Problems		
Bloody Phlegm			**CARDIOVASCULAR**		
Shortness of Breath			Chest pain		
No Problems			Irregular heart beat		
GASTROINTESTINAL			Difficulty breathing		
Pain with swallowing			Leg cramps		
Stomach pain			No Problems		
Vomiting			**NEUROLOGICAL**		
Bloody stools			Numbness		
Black stools			Developmental problems		
Constipation			Tremor		
No Problems			Balance problems		
SKIN			Poor Memory		
Change in skin or nail texture			No Problems		
Itchy Skin			**ENDOCRINE**		
Hives			Excessive thirst		
Dry skin			Temperature intolerance		
Hair loss			Poor growth		
No Problems			No Problems		
LYMPHATIC					
Inguinal node tenderness					

For nurse:

VITAL SIGNS

BP TEMP PULSE HT WT Taken By:

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International prostate symptom score (IPSS)

Name _____ **Date** _____

(Please complete in BLACK ink)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia Over the past month, **HOW MANY TIMES** did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	
Total IPSS Score							

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly Satisfied	Mixed- about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that? Your Score	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

URINARY MEDICATIONS:

☐ Flomax 0.4 mg caps ☐ Once a Day ☐ Twice a Day

☐ Rapaflo 8 mg caps ☐ Once a Day

☐ Cardura (Doxazosin) Dose: _____

Name:_____ **Date of Birth**: _____ **Date**:_____

SHIM Score

PATIENT INSTRUCTIONS: Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of a very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and **only one response for each question.**
OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?

Very low	Low	Moderate	High	Very high
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual Activity	Almost never or none	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost Always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt intercourse	Almost never or none	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost Always or always
0	1	2	3	4	5

4. During sexual intercourse how difficult was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt intercourse	Almost never or none	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost Always or always
0	1	2	3	4	5

6. Do you use a Prescription Drug/Physical Device to help you obtain an erection? ☐ Yes ☐ No

SCORE: _____
Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak to your doctor.

Patient Name: _____ **Date:** _____

Rectal Function Assessment Score (RFAS)

Respond regarding your experience during the past week

(Please complete in BLACK ink)

1. Number of bowel movements per day:

- ☐ 0 – 1 BM per day
- ☐ 2 BMs per day
- ☐ 3 BMs per day
- ☐ 4 or more BMs per day

2. Consistency of stools:

- ☐ All stools formed
- ☐ Stools formed and loose
- ☐ Stools loose
- ☐ Watery stools

3. Urgency of stools:

- ☐ No urgency
- ☐ Somewhat urgent
- ☐ Urgent
- ☐ Very urgent

4. Abdominal discomfort:

- ☐ No discomfort
- ☐ Mild to moderate discomfort
- ☐ Somewhat severe discomfort
- ☐ Very severe discomfort

5. Hemorrhoidal discomfort:

- ☐ No discomfort
- ☐ Requires mild treatment (i.e. tucks, sitz baths)
- ☐ Requires topical medication (i.e. Prep H, etc.)
- ☐ Requires oral analgesics or narcotics for relief

6. Rectal bleeding:

- ☐ No rectal bleeding
- ☐ Blood on toilet paper: 1 time per week
- ☐ 2-3 times per week
- ☐ ≥ 4 times per week

7. Continence:

- ☐ Normal continence; able to control stool movements at all times
- ☐ Gas incontinence only; able to control stool movements but not gas
- ☐ Minor spotting or leakage of stool (up to coin size) about once per week
- ☐ Minor spotting or leakage of stool (up to coin size) more than once per week
- ☐ Significant leakage of stool (larger than coin size) about once per week
- ☐ Significant leakage of stool (larger than coin size) more than once per week

8. Nighttime bowel movements (total number of nights in last week that you had to get up from bed to have a bowel movement):

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ More than 4

9. Completeness of evacuation:

- ☐ Complete evacuation (requires one movement to completely empty bowel or feel you're "all done")
- ☐ Occasional multiple evacuations (about once a week feel like you're not "all done" or it takes more than one movement to finish)
- ☐ Frequent multiple evacuations (more than once a week feel like you're not "all done" or it takes more than one movement to finish)
- ☐ Requires enema to obtain complete emptying

10. Have you ever been diagnosed with Crohn's disease or ulcerative colitis? ☐ Yes ☐ No

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PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race _____ Ethnicity (Please mark with a checkmark) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Do Not Know ☐ Other

Preferred Language _____ ☐ Yes, I will need a translator. ☐ No, I do not need a translator.

Patient Employed By _____ Occupation _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Work: _____ May we leave a message? ☐ Yes ☐ No

Cell: _____ May we leave a message? ☐ Yes ☐ No

May we send you reminders? ☐ No ☐ Yes via Text ☐ OR ☐ Email

Communications over the internet and/or using an email system or a text messaging system may not be encrypted and may not be secure. If I selected "yes" to reminders via email or text, I acknowledge that there is no assurance of confidentiality when communicating via email or text, but I still prefer to communicate via the option(s) I selected above.

If **OK** to send text reminders, your Cell Phone Company/Provider: _____

Email Address _____
(If you do not have an email, please leave blank)

Patient Signature: _____

PRIMARY INSURANCE

Insurance Company _____ Ins. ID No. _____

Person Responsible for Account (if different than patient) _____
Last Name First Name Initial

Relationship to Patient _____ Birth date _____ Soc. Sec. # _____

SECONDARY INSURANCE

Insurance Company _____ Ins. ID No. _____

Subscriber Name _____ Relationship to patient _____ Birth date _____
(if different than patient)

PAYMENT AUTHORIZATION

I hereby authorize my benefits to be paid directly to Silicon Valley Oncology and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

Signature: _____ Date: _____

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PATIENT INTAKE FORM

EMERGENCY CONTACT INFORMATION

Name: _____

Relation: _____

Address: _____

Phone Number: _____

Do you have an Advanced Directive? ☐ YES ☐ NO

Will you provide a copy? ☐ YES ☐ NO

Do you have a surrogate decision maker? ☐ YES ☐ NO

Have you made any changes to your Advanced Directive since this copy? ☐ YES ☐ NO

SILICON VALLEY ONCOLOGY | The US Oncology Network

Patient Acknowledgement Form
Notice of Privacy Practices and Patient Bill of Rights

☐ I have received a copy of the Notice of Privacy Practices and Patient Bill of Rights from Silicon Valley Oncology. I understand that Silicon Valley Oncology has the right to change its Notice of Privacy Practice from time to time and that I may contact Silicon Valley Oncology at any time to obtain a current copy.

Patient's Name: _____ DOB: _____/_____/_____

Patient's Signature: _____ Date: _____/_____/_____

☐ Patient declined the Notice of Privacy Practices and Patient Bill of Rights from Silicon Valley Oncology.

Staff's Signature: _____

Please check all that Apply:

1) Silicon Valley Oncology may disclose my information to:
___Any health care provider or facility
___Spouse (Name) _____
___Children (List names) _____
___Other (List name) _____

2) The physician/practice may use or disclose the following protected health information:
___ All test results ___The entire medical chart ___Chart notes only

3) What type of information would you like to maintain as non-disclosed:
___Nothing

(Fill in reason and the information that you do not wish to disclose.) _____

_____

_____

4) May we leave a detailed message at:
___ Home ___Cell ___Work

I understand that it is my responsibility to notify Silicon Valley Oncology Center in writing if I want to make any changes to the above.

Patient's Signature: _____

Print Name: _____ DOB: _____/_____/_____

Patient Copy

SILICON VALLEY ONCOLOGY | The US Oncology Network

PRIVACY DISCLOSURE

Policy: To establish guidelines for maintaining patients' personal privacy, respect and dignity while at the treatment center.

Procedure: Each patient shall receive the same compassionate care. The patient rights notice will be posted in the reception area. The following criteria will be followed:

- All patients' privacy (including medical and financial records) and personal needs will be met with full respect to ensure that their dignity and personal care needs are addressed in a professional and appropriate manner.
- All patients shall have access to their medical record (unless access is specifically restricted by the radiation oncologist for medical reasons).
- All patients may receive if requested a detailed explanation of facility charges to include an itemized bill for services they received.
- All patients' medical records will be kept confidential.
- All patients have the right to refuse or withdraw consent for treatment or give conditional consent.

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the
5. Patient Rights guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
6. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
7. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

PRIVACY DISCLOSURE

8. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
9. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
10. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the California State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
11. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
12. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;
13. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient;
14. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility; and
15. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.c.8: 43E-6.

The administrator shall provide all patients and/or their families upon request with the name, addresses, and telephone numbers of the following offices where complaints may be lodged:

Division of Health Facilities Evaluation and Licensing
California State Department of Health

State of California
P.O. Box 997414, MS 7610
Sacramento, CA 95899-7414
Telephone: (916) 558-1784

PATIENT BILL OF RIGHTS

The administrator shall also provide all patients and/or their families upon request with the names, addresses, and telephone numbers of offices where information concerning Medicare and Medicaid coverage may be obtained.

Each patient receiving services in an ambulatory care facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

2. To be informed of services available in the facility, of the names and Professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment;

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health; or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, role and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patients' choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal;

8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

PATIENT BILL OF RIGHTS

9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the California State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. To be treated with, courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices or any attendance at religious services, shall be imposed upon any patient; and
12. To not be discriminated against because of age, religion, sex, nationality, or ability to pay or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.

I/We sign this with the knowledge and understanding that the rights of the patient can only benefit the patient’s interest and further, that these rights have been explained to me/us verbally.