Beverly Oncology and Imaging
Medical Group, Inc.

Office:______________ **Verified By:**______________ **Date:**__________

PATIENT REGISTRATION

Acct#:__________ DX:________

Name: ____________________________ Age _____ Sex __ DOB _______
(Last) *(First)*

Address ____________________ City ____________ Zip ______

SSN ____________ Daytime Tel. ____________ Cell Phone __________

Preferred method of communication: Phone ☐ Mail ☐ Email ☐ ____________

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Preferred Language__________

Race____________ Ethnicity ____________ Religion __________

Employer ________________________ Tel.# __________

____
(Address) *(City)* *(State)* *(Zip)*

Previous / Current Occupation ________________________

Spouse's Name ____________________ Occupation __________

Spouse's Employer ____________________ Employer Tel.# __________

Emergency Contact (*not living with you*) ________________ Tel.# __________

____
(Address) *(City)* *(State)* *(Zip)*

PHYSICIAN INFORMATION

(*It is important that you list* *__all__* *your physicians so that they can be kept informed of your treatment)*

Referring doctor __________	Family M.D. __________
Address __________	Address __________
__________	__________
Tel.# __________	Tel.# __________
Fax #: __________	Fax #: __________
NPI # __________	NPI # __________
Surgeon __________	Medical Oncologist __________ (chemo doctor)
Address __________	Address __________
__________	__________
Tel.# __________	Tel.# __________
Fax #: __________	Fax #: __________
NPI # __________	NPI # __________

(OVER PLEASE)

Rev: 6/03, 9/08, 3/09, 8/11, 3/12, 6/14

HOME HEALTH

Are you now or have you ever been under the care of a Home Health Agency? Yes ☐ No ☐

If yes, name of Agency and Tel. # ____

PATIENT DIRECTIVES

Do you have a Living Will for Healthcare*? Yes ☐ No ☐
**A living will provides specific directives about the course of treatment that is to be followed by health care providers and care givers.*

Do you have a Durable Power of Attorney**? Yes ☐ No ☐
***A Durable Power of Attorney is a legal document in which you have assigned a person (called an agent) to make medical decisions for you in the event you are unable to speak for yourself.*

My Agent for Durable Power of Attorney is ______________________ Tel.# ______________

Do you have a Prehospital Do Not Resuscitate (DNR) form? Yes ☐ No ☐

PRIOR RADIATION

Have you had prior radiation therapy? Yes ☐ No ☐

If yes, when? ________________ Where? ______________________________

____

CLINICAL TRIALS

Are you currently enrolled in a clinical trial? Yes ☐ No ☐

By my signature I acknowledge that I have been:

- Given information on my rights to consent to any medical or surgical treatment
- Given information on my rights to refuse any medical or surgical treatment that I may not want
- Given information on Patient Directives and I understand that my care will not be compromised by whether or not I sign a Directive

Patient Signature ______________________________ Witness ________________

Date __________________ Date __________________

cc: Patient ☐ Date __________________

Filed in Patient Medical Chart ☐ Date __________________

BEVERLY ONCOLOGY & IMAGING
Medical Group, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

120 W Beverly Boulevard
Montebello, CA 90640
Tel. (323) 724 8780
Fax. (323) 728 9936

1041 E. Yorba Linda Blvd #100
Placentia, CA 92870
Tel. (657) 444-1164
Fax. (657) 208-9759

80 S. Palm Avenue
Alhambra, CA 91801
Tel. (626) 571 6729
Fax. (626) 571 1170

11480 Brookshire Ave. # 100
Downey, CA 90241
Tel. (562) 861-9914
Fax. (562) 869-0034

12555 Garden Grove Blvd. # 101
Garden Grove, CA 92843
Tel. (714) 530-5930
Fax. (714) 530-5675

I hereby authorize ________________________________ M.D. to furnish medical

information concerning ______________________________ (patient) to Beverly Oncology & Imaging Medical Group, Inc. at the above checked address (California Civil Code 56.10, Title 17)

Type of Record(s) / Information to be Released:

Any and all information may be released ____________ (*Patient Initials*)

Specific Record(s) / Information specified below ____________ (*Patient Initials*)

____

Records pertaining to the treatment of Psychiatric / Mental Health (CAL W&I Code Section 5328); Alcohol / Substance Abuse (Section 42 Part 2 Code of Federal Regulations); HIV Results / AIDS Treatment (Health and Safety Code 120980) are covered under the confidentiality codes listed in parenthesis. Redisclosure of each of these types of records is prohibited without the specific written authorization of the person to whom the treatment pertains or as otherwise permitted by these regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THIS RELEASE SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: You may revoke this authorization to release information at any time. However, the information may have already been released on the basis of this authorization. **You must initial on one of the following for the request to become valid:**

____________ This authorization expires once information is released. This is a one time release.

____________ This authorization expires six (6) months after the signature date below.

____________ This authorization expires as specified ______________________________

______________________________ ____________________
Patient Signature *Date*

______________________________ ____________________
Printed Name *Date of Birth*

Rev. 4/03, 9/14
CTRA

BEVERLY ONCOLOGY & IMAGING
MEDICAL GROUP, INC.

PATIENT NAME: ____

PRIVACY OF MEDICAL INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Beverly Oncology & Imaging Medical Group, Inc.

I authorize Beverly Oncology & Imaging Medical Group, Inc. to release information about my medical condition to the following specified family members; caregiver; and/or friends:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

ACKNOWLEDGEMENT OF POTENTIAL MEDICAL SCREENING FOR CLINICAL TRIALS

By signing below I acknowledge that I have been advised that subject to the prior opinion of my physician; medical screening; and a selection process I may be a candidate for participation in a clinical trial relating to my medical condition and/or course of treatment. I hereby agree that Beverly Oncology & Imaging Medical Group, Inc. physicians and staff may exercise the minimum necessary access to my medical information for the purposes of preliminary medical screening.

I further acknowledge and agree that my medical information will not be released to any third party for further evaluation, further medical screening or for any selection process for clinical trials without my specific individual authorization for the release of such information.

____
Signature of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

____
Personal Representative's Address *Contact Tel. Number*

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ____________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ____________________ ________
Physician's or Authorized Representative's Signature (Date)

____
Print or Stamp Name of Physician, Medical Group, or Association Name

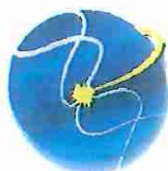
By: ____________________ ________
Patient's or Patient Representative's Signature (Date)

By: ____________________
Print Patient's Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Beverly Oncology & Imaging Medical Group, Inc. to furnish my insurance company, and/or my attorney, my other Doctor's, etc., all of the information concerning my present illness or injury.

Signed:______________________________

Date:______________________________

Los, Angeles, California

AUTHORIZATION FOR RELEASE OF INFORMATION

I______________________________hereby authorize______________________________

(name of insured) (name of Company)

To pay directly to Beverly Oncology and Imaging the surgical and/or medical benefits, if any, otherwise payable to me for his/her services but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by the insurance carrier.

Signed:______________________________

Date:______________________________

Los, Angeles, California

BEVERLY ONCOLOGY & IMAGING
Medical Group, Inc.

PATIENT NAME: ______________________________

FINANCIAL AGREEMENT
FINANCIAL POLICY / PAYMENT TERMS

PAYMENT IS DUE WHEN SERVICES ARE RENDERED:

We will, as a courtesy, bill most insurance companies for you, provided that we have all the necessary information.

In the event that your insurance company denies your claim or any part thereof, you are responsible for the balance in full.

For cash patients, we will require a minimum 20% deposit on your first visit with a further installment payable at the time of each subsequent visit. The balance of your treatment charge is required to be paid in full at or before the time of your final visit.

COPAYMENT AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED:

Insured patients are responsible for all charges not paid by the insurance company within 45 days after date of service. Payment arrangements can be made on an individual basis **at our discretion.** We reserve the right to withdraw the extension of credit.

OTHER TERMS:

I understand that I am financially responsible for all charges regardless of any insurance claims which may be pending.

I agree to pay reasonable costs of collection, plus interest at the maximum legal rate, for any amounts due but unpaid under this agreement.

Should I receive a direct payment by my insurance company for the services provided by Beverly Oncology & Imaging Medical Group, Inc., I agree to forward such payment(s) directly to Beverly Oncology & Imaging Medical Group, Inc. within 48 hours of receipt of such payment.

Subject to the provisions of the HIPAA Privacy Rule I authorize Beverly Oncology & Imaging Medical Group, Inc. to release such medical information as may be necessary to process an insurance and/or benefits claim.

I authorize my insurance and/or benefits provider to pay directly to Beverly Oncology & Imaging Medical Group, Inc. the medical and/or surgical benefits pertaining to my treatment and understand that I am financially responsible for those charges not met by my insurance and/or benefits.

Signature: ______________________________ *Date:* ______________________

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST COMPLETE AND SIGN THIS FORM

Filed in Patient Medical Chart ☐ Date ______________________

Beverly Oncology and Imaging Medical Group, Inc.

Patient Health Questionnaire (PHQ-9)

Name: ______________________ DOB: ______________ Date: ____________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself- or that you're a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people have noticed. Or, the opposite – being fidgety or restless that that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Column Totals ______ + ______ + ______ + ______

Add Totals Together: ________

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Provider Signature: ______________________________ M.D.

Print Provider Name: ______________________________ Date: ______________

Beverly Oncology and Imaging Medical Group, Inc.

Pregnancy Status Questionnaire

Patient name: ______________________________ DOB: ________________

Please answer the following questions:

1) Date of your last menstrual period month ________ day ________ year ________

2) Have you had a hysterectomy? ☐ Yes ☐ No If yes, when?
   month ________ day ________ year ________

3) Have you had a tubal ligation? ☐ Yes ☐ No If yes, when?
   month ________ day ________ year ________

4) Are you taking birth control pills? ☐ Yes ☐ No

5) Any other methods of birth control? ☐ Yes ☐ No If yes, please describe

____

6) Are you planning to become pregnant? ☐ Yes ☐ No

7) Have you had a recent pregnancy test? ☐ Yes ☐ No If yes, when?
   month ________ day ________ year ________

______________________________ ______________________

Patient signature Date

______________________________ ______________________

RN/LVN/MA signature Date

______________________________ ______________________

Reviewing physician signature Date

Beverly Oncology and Imaging

Medical Group, Inc.

SCREENING FORM FOR IMAGING

Patient Name: ______________________________ DOB: ______________ Date: ______________

MRI

Any history of:

Pacemaker	___Yes	___No
Metalic Ear Tubes/Prosthesis	___Yes	___No
Aneurysm clips in head	___Yes	___No
Metalic surgical clips	___Yes	___No
Metal worker (weld, gring, etc.)	___Yes	___No
Metal Orthopedic devices	___Yes	___No
Dental appliances	___Yes	___No
Sharpnel	___Yes	___No
Other implanted metal	___Yes	___No
IUD	___Yes	___No
Pregnant at present	___Yes	___No
Bullet wound	___Yes	___No
	___Yes	___No
CT	___Yes	___No
Allergic to iodine or seafood	___Yes	___No
Diabetes	___Yes	___No
Are you taking metformin, glucophage, or glucovance?	___Yes	___No

MRI

Tiene historial de:

Marcapasos	___Si	___No
Tubos Metalicos en el oido/Protesis	___Si	___No
Metales para Aneurisma el la cabeza	___Si	___No
Metales quirurgicos	___Si	___No
Trabajadoe de metals (soldadura, etc.)	___Si	___No
Dispositivos Ortopedicos de Metal	___Si	___No
Dentadura postiza (puentes, parciales, etc.)	___Si	___No
Tiene algun fragment de metal en alguna parte de su cuerpo?	___Si	___No
Algun otro metal implantado	___Si	___No
Dispositivo intrauterino	___Si	___No
Esta embarazada?	___Si	___No
Herida de bala	___Si	___No

CT

Alergia al yoda o mariscos	___Si	___No
Diabetes	___Si	___No
Esta tomando metformin, glucophage, or glucovance?	___Si	___No

HEALTH QUESTIONNAIRE

NAME ______________________ AGE ________ DATE ____________

ADDRESS ______________________ PHONE ____________

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles .... No Yes
Mumps .... No Yes
Chickenpox .... No Yes
Diabetes .... No Yes
Strokes .... No Yes
Cancer .... No Yes

Rheumatic fever or heart disease .... No Yes
Tuberculosis .... No Yes
Venereal disease .... No Yes
Congenital abnormalities .... No Yes
Other serious diseases: .... No Yes
____

Adult:

Have you had any serious illness? .... No Yes
Have you ever had radiation therapy? .... No Yes
If yes, when? ______________ what part of your body? ______________
Have you ever been hospitalized or been under medical care for very long? .... No Yes
Have you ever had chemotherapy? .... No Yes
If yes, when? ______________ How many chemo treatments did you receive? ______________
If yes, for what reason? ______________

Operations:

Have you had any surgery? .... No Yes
List ______________ date ________ ______________ date ________
______________ date ________ ______________ date ________
______________ date ________ ______________ date ________

Injuries:

Have you had any broken bones? .... No Yes
If yes, which bone? ______________ Which side? ______________ Date: ________
Have you had any head concussions or injuries? .... No Yes
Have you ever been knocked unconscious? .... No Yes

FAMILY HISTORY:	If Living: Age	Health	If Deceased: Age (of death) and Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High blood pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Lupus or other collagen disease	No	Yes
					Mental illness	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed
Are you living with your husband or wife? .... No Yes
Is your sex life satisfactory? .... No Yes
Do you have dependents at home? .... No Yes
Alcoholic beverages: Never ________ Rarely ________ Moderately ________ Daily ________ Ever? ________ .... No Yes
If yes, how much did you drink? ______________ When did you start? ________ When did you stop? ________
Tobacco: Cigarettes ________ Packs per day ________ Don't smoke ________ Ever smoked? ________ .... No Yes
If yes, when did you start smoking? ______________ When did you stop? ______________
Are you employed? Full time ________ Part time ________ What is your job? ______________
Are you exposed to fumes, dusts, solvents, or asbestos? .... No Yes

Education: Years

Grade School ______
High School ______
College ______
Postgraduate ______

How much time have you lost from work because of your health during the past?:
Six Months ______________
One Year ______________
Five Years ______________

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change .... No Yes
Have you been in good general health most of your life? No Yes

Skin:

Skin disease .... No Yes
Jaundice .... No Yes
Hives, eczema or rash .... No Yes
Frequent infection or boils .... No Yes
Abnormal pigmentation .... No Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury .... No Yes
Do you wear glasses? .... No Yes
Double vision .... No Yes
Headaches .... No Yes
Glaucoma .... No Yes

Head-Eyes-Ears-Nose-Throat (continued):

Sneezing or runny nose .... No Yes
Nosebleeds .... No Yes
Chronic sinus trouble .... No Yes
Ear disease .... No Yes
Impaired hearing .... No Yes
Dizziness or transient episodes of unconsciousness .... No Yes

Neck:

Stiffness .... No Yes
Thyroid trouble .... No Yes
Enlarged glands .... No Yes

Respiratory:

URI (cold) now .... No Yes
Chronic or frequent cough .... No Yes

Itchy eyes or nose	No	Yes

Respiratory (continued):

Asthma or wheezing	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or pneumonia	No	Yes

Cardiovascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath with walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movement	No	Yes
Bleeding with bowel movement	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or pain in the abdomen	No	Yes
Does food stick in throat	No	Yes

Genitourinary:

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Urinary infection	No	Yes
How many urinary infections in the past year ________		
Difficulty emptying the bladder	No	Yes
Cloudy or foul smelling urine	No	Yes
Kidney problems	No	Yes
Kidney stones	No	Yes
Bright's disease	No	Yes
Spitting up blood	No	Yes

Gynecological:

Age periods started ________________

How long do periods last? ________________ days

Number of pregnancies ________________

Number of miscarriages ________________

Date of last pap smear and results ________________

____

Frequency of periods, every ____________ days		
Any pain with your periods	No	Yes

Number of children ________ Ages ________________

Date of first day of last period ________________

Locomotor-Musculoskeletal:

Varicose veins	No	Yes
Weakness of muscles or joints	No	Yes
Any difficulty in walking	No	Yes
Any pain in calves or buttocks on walking relieved by rest	No	Yes

Neuro-Psychiatric:

Have you ever had psychiatric care?	No	Yes
Have you been advised not to see a psychiatrist?	No	Yes
Do you ever have, or have had, fainting spells?	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematologic:

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery?	No	Yes
Have you had abnormal bruising or bleeding?	No	Yes

Allergies:

Any allergies, including medication	No	Yes

Endocrine:

Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before or skin become dryer	No	Yes

HEIGHT ________________________

WEIGHT ________________________

Are you currently participating in a clinical trial?	No	Yes
Are you interested in clinical trials?	No	Yes

ALLERGIES AND SENSITIVITES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of :

	Circle One		
Penicillin or other antibiotics	No	Yes	Don't know
Morphine, Codeine, Demerol or other narcotics	No	Yes	Don't know
Novocain or other anesthetics	No	Yes	Don't know
Aspirin, Empirin or other pain remedies	No	Yes	Don't know
Sulfa drugs	No	Yes	Don't know
Tetanus antitoxin or other serums	No	Yes	Don't know
Adhesive tape	No	Yes	Don't know
Iodine or merthiolate	No	Yes	Don't know
Any other drug or medication	No	Yes	Don't know
Any foods, such as eggs, milk or chocolate	No	Yes	Don't know

Tranquilizers	No	Yes
Hypotensives (high blood pressure medicine)	No	Yes
Aspirin	No	Yes

What drug or Food?

____

____

____

____

____

____

____

____

2. **Drugs recently taken (within the past six months):**

Cortisone	No	Yes	Don't know
ACTH	No	Yes	Don't know
Anticoagulants	No	Yes	Don't know
Has the patient ever received treatment for: asthma, rheumatism or rheumatic fever?	No	Yes	Don't know

Source of information, if other than patient: ____

Signature of person acquiring this information: ____

________________________ ________________ ________________________

Doctor | Date | Signature of patient

Rev : 12/08