Patient Registration Form: Oncology Service

MASSACHUSETTS GENERAL HOSPITAL
ORTHOPAEDICS

Tell us about yourself

Name: _____ DOB: _____ MGH Medical Record #: _____

Date of Injury: _____ Height: _____ Weight: _____

Workers Comp? ☐ Yes ☐ No Claim # & Case Manager: _____

Best way to contact you? ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Phone #: _____ Best time to call: _____ Email Address: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

_____ _____

Phone Number: _____ Phone Number: _____

Present Medical History: Oncology Service

Have you been diagnosed with: ☐ soft tissue mass/tumor ☐ bone lesion/tumor

Location of tumor/mass/lesion: _____ Has the tumor been biopsied? ☐ Yes ☐ No

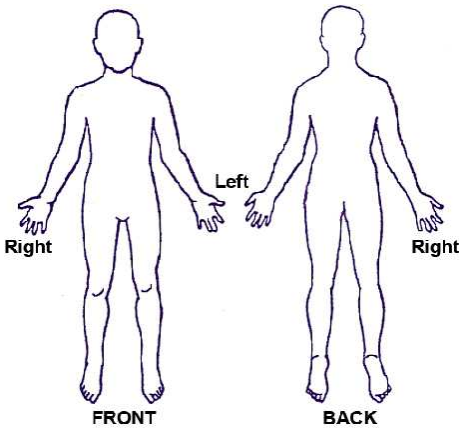
Have you had prior:				
	Chemotherapy	☐ Yes	☐ No	Type: _____
	Radiation	☐ Yes	☐ No	Amount: _____
	Surgery	☐ Yes	☐ No	Type: _____

Side effects of treatment: _____

Pain Chart

Mark the areas on the bodies where you feel sensation. If there are different sensations in different places, please write what the different sensations are.

If you are filling this out on the computer, please mark the areas after printing the completed form.



Pain Severity

Is your pain (check only one)? ☐ Constant ☐ Occurring daily ☐ Occurring most days ☐ Infrequent

How would you describe the pain (choose as many adjectives as are applicable)?

☐ Burning ☐ Throbbing ☐ Electric-like ☐ Pins/needles ☐ Penetrating ☐ Shooting

☐ Sharp ☐ Stabbing ☐ Tearing ☐ Aching ☐ Gnawing ☐ Dull

☐ Miserable ☐ Other: _____

Circle your average level of pain over the past month

10 9 8 7 6 5 4 3 2 1 0

Severe pain No pain

Circle your current level of pain

10 9 8 7 6 5 4 3 2 1 0

Severe pain No pain

Medications (Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.)

Current Medication(s)	Dose	Frequency

Your pharmacy (name, location) _____

Surgical / Hospitalization History

Year	Surgeries / Hospitalizations	Complications

Have you ever been isolated during hospitalization for MRSA, VRE, TB, c. difficile colitis or other infectious diseases? ☐ Yes ☐ No

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*Fill this out thoroughly and save a copy for future healthcare reference

Family History

Please check family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Osteoporosis ☐ Cancer ☐ Kidney Disease ☐ Liver Disease
☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Seizures ☐ Rheumatoid Arthritis ☐ Gout

Mother: ☐ Alive ☐ Deceased Age: ____ Medical problems: _____
Father: ☐ Alive ☐ Deceased Age: ____ Medical problems: _____
Sibling(s): ☐ Alive ☐ Deceased Age: ____ Medical problems: _____

Social History

Occupation: _____ ☐ Part-time ☐ Full-time ☐ Retired ☐ Not working ☐ SSDI
Marital status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed
Do you live alone? ☐ Yes ☐ No Who lives with you? _____
Do you have children? ☐ Yes ☐ No How many? _____
Tobacco use? ☐ Current (___ packs per day for ___ years) / ☐ Quit (year ___) / ☐ Never
Alcohol use? ☐ Current (☐ daily / ☐ weekly / ☐ less often) / ☐ Quit (year ___) / ☐ Never
Caffeinated drinks? ☐ Yes ☐ No Frequency: _____
Recreational drug use? ☐ Yes ☐ No Type: _____ Frequency: _____
History of alcohol or drug abuse? ☐ Yes ☐ No
Do you have a special diet? ☐ Yes ☐ No Any restrictions? _____
Have you lost or gained 10+ pounds in the last 3 months without trying or wanting to? ☐ Yes ☐ No
Have you had any difficulties with the following: ☐ Walking ☐ Personal hygiene ☐ Toileting
☐ Eating / drinking / swallowing ☐ Getting into or out of bed ☐ History of falls ☐ Dressing
Do you exercise regularly? ☐ Yes ☐ No How often? _____
What exercise do you do? _____
Is there anything that restricts you from doing the activities you want to do? ☐ Yes ☐ No
Have you ever felt unsafe or been afraid of anyone? ☐ Yes ☐ No

Past History

Please list any prior illness and/or injuries: _____

Please list allergies & reactions: To medications: _____

Latex allergy: ☐ Yes ☐ No Other allergies (to food, pollen, etc): _____

Have you ever had problems with anesthesia? ☐ Yes ☐ No
If yes, please explain: _____
Have you experienced post-operative nausea and vomiting? ☐ Yes ☐ No
Have you been exposed to Hepatitis? ☐ Yes ☐ No Have you been exposed to AIDS? ☐ Yes ☐ No

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Review of Health Systems: Have you ever had problems with, or are currently suffering from, any of the following:

HOW YOU FEEL IN GENERAL	***LUNGS***	***IMMUNE SYSTEM***
☐ Fever	☐ Asthma, wheezing, chronic cough	☐ Undergone chemo
☐ Unexpected weight loss	☐ Emphysema , COPD	☐ Undergone radiation
☐ Loss of appetite	☐ Shortness of breath	☐ Stem cell transplant
☐ Excessive fatigue	☐ Bronchitis or pneumonia	☐ Organ transplant
☐ Night sweats	☐ Tuberculosis	
	☐ Sleep apnea	***MUSCLES & BONES***
EYES, EAR, NOSE, THROAT & MOUTH	☐ Blood clots	☐ Broken bones? Which _____
☐ Glasses/contacts ☐ Double vision		☐ Limb weakness, numbness
☐ Glaucoma	***KIDNEYS & URINE***	☐ Limb stiffness
☐ Hearing loss ☐ Wear hearing aid	☐ Bladder cancer	☐ Back pain, spinal conditions
☐ Ringing in ears	☐ Urinary tract infections	☐ Scoliosis
☐ Sinus problems	☐ Kidney stones ☐ Kidney disease	☐ Arm pain
☐ Dental issues _____	☐ Difficulty urinating or blood in urine	☐ Leg pain or sciatica
	☐ Prostate problems	☐ Joint pain or swelling / arthritis
BRAIN & NERVES		☐ Fibromyalgia
☐ Fainting spells or “blacking out”	***GLANDS***	☐ Reflex Sympathetic Disorder
☐ Seizures	☐ Diabetes	☐ Osteoporosis
☐ Balance problems	☐ Thyroid Disease / Disorder	☐ Instability / giving way
☐ Headaches ☐ Loss of memory	☐ Hormone problems	☐ Dislocated joints
	☐ Taken Prednisone	☐ Excessive flexibility of joints
HEART		☐ Bone infections
☐ Chest pain/angina	***GYNECOLOGICAL***	☐ Ambulatory support? i.e. cane, walker, brace, prosthesis, etc.
☐ Last EKG _____	☐ Breast, ovarian, cervical cancer	
☐ High blood pressure	☐ Abnormal pap smear	
☐ Irregular pulse	☐ Menstrual cycle problems	***GAIT/MOTION***
☐ Heart Murmur ☐ Heart Attack	☐ Fibroid tumors	☐ Cerebral palsy
☐ Elevated cholesterol	☐ Breast lump/nipple discharge	☐ Parkinson's Disease
☐ Calf pain when walking		☐ Paralysis
☐ Bypass surgery	***SKIN***	☐ Multiple sclerosis
☐ Stent or pacemaker	☐ Skin cancer	
	☐ Eczema ☐ Psoriasis	***YOUR FEELINGS***
STOMACH & INTESTINES	☐ Skin ulcers ☐ Chronic rashes	☐ Anxiety
☐ Nausea, vomiting		☐ Depression
☐ GERD/heartburn	***BLOOD***	☐ Claustrophobia
☐ Ulcers ☐ Gastritis	☐ Anemia ☐ Hemophilia	☐ ADD / ADHD
☐ Colon cancer	☐ Swollen glands, lymph nodes	☐ Bi-polar disorder
☐ Hepatitis	☐ Decreased resistance to infection	☐ Schizophrenia
☐ Jaundice and/or liver problems	☐ Blood transfusion? When _____	☐ Autism
☐ Blood in stool	☐ Easy bleeding or easy bruising	☐ Altered mental status (stroke, Alzheimer's, etc)
☐ Constipation, diarrhea	☐ Blood cancer	

Please contact MassGeneral Registration Referral Center at 1-866-211-6588 and update your demographic and insurance information. I hereby authorize my insurance benefits to be paid directly to Massachusetts General Physician Organization (MGPO) and acknowledge that I am responsible for any balance not covered by those benefits. I authorize MGPO to release information requested concerning my care to insurers paying such benefits.

To the best of my knowledge, my answers are correct

Sign your name _____ Today’s date _____

I have reviewed the above information with the patient

Physician’s name _____ Date _____ Time _____

Physician’s Signature _____

Name: _____ MGH Medical Record #: _____

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