Bay Area Gynecology Oncology
455 O'Connor Drive, Suite 370, San Jose, CA 95128
P# 408-827-4274 F#408-827-4275

Patient Registration Form

Circle One

Patient Name: _____ **Date of Birth:** _____ FEMALE MALE

ADDRESS: _____ **CITY** _____ **ST**_____ **ZIP**_____

Home Phone: (_____)_____ **Cell**: (_____)_____ **Work Phone**: (_____)_____

SSN:_____-_____-_____ **EMAIL**: _____

Circle if okay to leave messages at: **HOME** **WORK** **CELL** **Marital Status** (circle): S M W D

EMPLOYER: _____PHONE: (_____) _____

Race:_____ Ethnicity:_____ Primary Language: _____

** **EMERGENCY CONTACT**:**

Name: _____ PHONE: (_____) _____Relation: _____

Address, City State Zip: _____

Pharmacy Name & Location:_____**Pharmacy Phone:** _____

General Practitioner Internist: _____ Gynecologist: _____

Cardiologist: _____ Other Specialist:_____

Referring Physician: _____ Phone: _____

Reason for visit today:_____

THE FOLLOWING MUST BE COMPLETED ALONG WITH BRINGING IN YOUR INSURANCE CARD

PRIMARY INSURANCE CARRIER:_____

ID #: _____ MEDICAL GROUP: _____

INSURES'S NAME: _____INSURED'S **DOB**: _____

SECONDARY INSURANCE CARRIER:_____

ID #: _____ MEDICAL GROUP: _____

INSURES'S NAME: _____INSURED'S **DOB**: _____

SIGNED: _____ **DATE**: _____

Today's Date: ______________

BAY AREA GYNECOLOGY ONCOLOGY
PATIENT HEALTH ASSESSMENT

Patient Name: ____ Date of Birth: ______________________

Reason for visit today: ____

General Practitioner Internist: ______________________ Gynecologist: ___________________________________

Cardiologist: ___________________________________ Other Specialist:_________________________________

PREVIOUS HEALTH SCREENING TESTS

Name of Test	**Date (X=never)**	**Result**
Colonoscopy/ Sigmoidoscopy		
Bone Density Scan		
Chest X-ray		
CA 125 Blood Test		
CT Scan		
PET/MRI/Ultrasound		

MEDICATIONS, *Supplements, Herbs & other Alternative Treatments*

NAME	**DOSE**	**REASON**
ASPIRIN Y N (Circle Y for Yes & N for No)		

~*

For Office use ONLY:

Height: ________ Weight: ____________ B/P: ____________ Temp: ____________ P: ____________

MEDICAL HISTORY

(Circle Y for Yes and N for No)

Breast Disease
Last Mammogram Date:
_____
Normal or Abnormal?

Gastrointestinal
Y N Hepatitis
Y N Ulcers
Y N Intestinal disease
Y N Abdominal Pain
Y N Change in bowel habits
Y N Blood in stool
Y N Constipation
Y N Diarrhea
Y N Ulcerative colitis

Kidney Disease
Y N Kidney Stones
Y N Other Kidney Disease
Y N Dialysis
Y N Painful Urination
Y N Blood in Urine
Y N Urinary Incontinence
When coughing, laughing, sneezing?
Y N Urinary Urgency
Or frequency

Hematologic Disease
Y N Bleeding Disorder
Y N Frequent nosebleeds
Y N Previous blood Transfusion

Muscle/ Joint Disorders
Y N Arthritis
Y N Leg Pain
Y N Back Pain
Y N Muscle Weakness

Eye Disease
Y N Glaucoma
Y N Cataracts
Y N Macular Degeneration

Neuro
Y N Stroke
Y N Seizures
Y N Migraines / Chronic Headaches
Y N Weakness
Y N Numbness
Y N Loss of consciousness
Y N Hot Flashes

Endocrine
Y N Hypothyroid
Y N Hyperthyroid
Y N Diabetes
Y N Steroid Use

Cardiology
Y N Heart Attack
Y N Irregular heart rate
Y N High Blood Pressure
Y N Rheumatic Fever
Y N Pacemaker/ Defibrillator
Y N Angina, chest pain

Last EKG Date (if any):
_____

Respiratory
Y N Asthma
Y N Steroid Use
If yes, date last used
_____
Y N Emphysema
Y N Bronchitis
Y N Pneumonia
Y N Blood Clot
Y N Sleep apnea
Y N Short of Breath (SOB)
Y N SOB w/ exertion

Skin
Y N Skin disease
Y N Rashes
Y N Lumps in Breast

Gynecologic
Last Menstrual Period
_____
(If Menopausal, list year)

Last Pap Test Date:
_____
Normal or Abnormal?

Y N Hormone Replacement

Reproductive
Y N Possibility of being Pregnant now
_____# of pregnancies
_____# vaginal delivery
_____# C-section
_____# Early Termination pregnancies
_____# Miscarriages
_____# Living Children

Y N Desire to have more children?

Do you have other medical conditions not listed?
If so, please explain: _____
_____
_____
_____
_____

ALLERGIES

Name	Reaction
LATEX Y N	

PREVIOUS SURGERIES / RADIATION / CHEMOTHERAPY

Procedure	Year	Type of Anesthesia	Complications

HOSPITALIZATION (Other than Listed above)

Reason	Month / Year

PERSONAL INFORMATION

Has anyone in your family had cancer? Y N

If so, how are they related (maternal/paternal) and what type of cancer?

_____

_____

SOCIAL HISTORY

Do you use recreational drugs? (i.e. marijuana, cocaine, Opiates etc…) Y N

If so, please list types: _____

Are you a current or former smoker? Y N

If current, please list # packs a day: _____

If former, please state date stopped: _____

Do you drink alcohol? Y N

If yes, please list # drinks per day: _____

Have there been any significant weight changes recently? Y N

If yes, please explain: _____

FORM TRANSLATED BY:

This form has been translated for the patient by:

Translated by: _____

Translator Signature: _____ Date: _____

Bay Area Gynecology Oncology * 555 Knowles Dr St 203, Los Gatos CA 95032

Patient Consent/Agreement Form

NAME: _____ DOB: _____

CONSENT FOR TREATMENT
I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. This may include the administration of needed anesthetics, the use of prescribed medication, the use of diagnostic procedures and the use of x-rays and laboratory test.

RELEASE OF INFORMATION
I authorize the release of any medical information to and from any medical facilities, physicians, and/or my insurance company.

I also authorize the following person(s) to receive any of my medical information:

_____

PRIVACY POLICY ACKNOWLEDGEMENT
I acknowledge that I have been given ***The Notice of Privacy Practices*** for Bay Area Gynecology Oncology.

PAYMENT: I understand that I am responsible for payment for services **including co-payments**, balances and charges for services not covered by insurance. All payments are due at the time of service. I authorize the payment of insurance benefits to one of the following, James Lilja, M.D., Jeff F Lin, M.D., or Bay Area Gynecology Oncology. I understand that **late** payments may incur a charge of 5% interest, per day, until paid.

REFERRAL/AUTHORIZATIONS: I agree to provide a referral or an authorization from my PCP-Primary Care Physician or referring physician if my insurance is an HMO at the time of my visit. If no referral form is provided, my visit may be re-scheduled.

MEDICAL RECORD COPIES/DISABILITY FORM CHARGES: Disability form completion and copying of medical records incur a $50.00 charge and will not be completed without payment.

CHANGE OF ADDRESS AND/OR INSURANCE:
I agree to notify Dr. Lilja's office of any changes to my address, phone number, employment, and, insurance. I have read all the above information on this sheet and have agreed that (regardless of my insurance) I will pay for all Medical Services provided by James Lilja MD or any health care professional acting on their behalf. **As a courtesy**, our billing service will assist you in filling your insurance claim, within reasonable bounds. This office will expect prompt payment from your insurance company (usually within 30 days of the billing date). If this is not the case, we ask that you help us collect from your Insurance Carrier or settle your bill at the end of this time period.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the release of any **Medical Information** necessary to process these claims, and I request payment of insurance benefits to: James Lilja, M.D., Jeff F Lin, M.D. and/or Bay Area Gynecology Oncology. I agree that unpaid insurance balances are my full responsibility. I also authorize the release of any information acquired in the course of my examination or treatment to hospital, other physicians, and/or my insurance company. Ultimately I am responsible for the balance of my account for any services and/or charges rendered.

LATE/NO SHOW FEES: I agree to appear **within 15 min of my appointment time**. I agree to notify the office if I must cancel an appointment **greater than 24 hours prior to my appointment**. If I fail to do so, I agree to pay the Charges for a 15 min office evaluation (indexed to the current year).

TRANSLATION: I authorize the following person(s) to provide translation services:_____

RX HUB INQUIRY: I hereby provide consent for the Practice of Bay Area Gynecology Oncology, to obtain my Rx history using the SureScripts-Rx Hub Network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx has certified Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system to system communications.

_____ _____
Patient / Guardian Signature Date

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: Dr. James Lilja

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	—	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

FHQ/09-11

MYRIAD®

SCREENING FORM FOR OUR REHABILITATION PROGRAMS

We understand you have answered many medical questions but we ask you to take a few more moments to help us understand how satisfied you are with your quality of life. We can provide services to improve many aspects of daily living but first we need to know what issues you are having.

Below is a list of statements that other people with your illness have said are important. Please mark the box to indicate your response as it applies to the past two weeks.

	Not at all	A little bit	Somewhat	Quite a bit	Very Much
I have a lack of energy					
I have pain					
I have nausea					
I worry that my condition will get worse					
I am sleeping well					
I am able to enjoy life					
I am content with the quality of my life right now					

Over the past two 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
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself-or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that would be better off dead, or of hurting yourself in some way?				

Please mark the box to indicate your response as it applies to the past two weeks.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am interested in sex					
Sex is painful					
I am afraid to have sex					
I am bothered by itching/burning in my vulva area					
My vagina feels too narrow or short					
I have trouble controlling my urine					

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am confident in my knowledge of nutrition as it relates to my cancer					
I have been eating poorly because of a decreased appetite					
Poor appetite or overeating					
I have recently lost weight without trying to					

NAME and DATE_____

Do you have anything you would like to talk with the doctor about today? _____

_____

_____

Symptoms? _____

Complaints? _____

Problems with medications or pain? _____