Revolutionizing Treatment * Restoring Hope * Improving Lives

6802 S. Olympia Ave., Suite G100

Tulsa, Oklahoma 74132

Phone: 918-949-6676 Fax: 918-949-6670

Please fill out the all paperwork and bring it along with your photo ID and medical insurance cards to your initial office visit.

Thank You!

DATE: ______________________________

REFERRING PHYSICIAN: ____

PRIMARY CARE PHYSICIAN: ____

NAME: ____
Last First MI

Reason/Problem for Visit: ____

Employer: ____ Employer Phone: __________________

Retired: Yes or No Year of Retirement: ________________

Email address (only used to send patient satisfaction survey):
____

EMERGENCY CONTACTS:

Name: ____ Relationship: ____________________________

Phone: ____ Cell: ____________________________________

Name: ____ Relationship: ____________________________

Phone: ____ Relationship: ____________________________

Are you Claustrophobic: Yes or No

Name of Your Pharmacy: ____

Phone: ____ Fax: ____________________________________

Are you an Organ Donor: Yes or No

Do you have an Advanced Directive or Living Will? Yes or No

If yes, date signed: ______________________________

Please answer the following questions to the best of your ability. If you have a problem completing any section, please ask the doctor/nurse for an explanation.

Have you ever been treated with radiation? Yes / No Date: ___________________________

Name & Location of the treating radiation facility:

____

Do you have a pacemaker or defibrillator? Yes / No

Have you been diagnosed with any chronic illness? (Diabetes, high blood pressure, etc.)

____

Have you ever been admitted to a hospital for any of the following surgeries, other than for childbirth? (Circle Yes or No).

Tonsillectomy	**Yes**	**or**	**No**	**Breast Biopsy**	**Yes**	**or**	**No**
Appendectomy	**Yes**	**or**	**No**	**Mastectomy**	**Yes**	**or**	**No**
Hysterectomy	**Yes**	**or**	**No**	**Colon/Rectal Surgery**	**Yes**	**or**	**No**
Gallbladder	**Yes**	**or**	**No**	**Prostate**	**Yes**	**or**	**No**
Bronchoscope	**Yes**	**or**	**No**	**Hemorrhoidectomy**	**Yes**	**or**	**No**
Lung Surgery	**Yes**	**or**	**No**				

List any other surgeries not mentioned above:

____

____

Have you ever had any complications with anesthesia in the past? If yes, what issues did you experience?

____

____

Do you have any allergies to medications, food or environment (i.e. dust)?

____

Please list all current medications including the name, the dosage, and how many times a day you take it:

____

____

____

____

____

____

____

____

Have you every smoked? Yes or No

If yes, number of packs per day: _________ How many years: _________ Quit date: __________

Do you consume alcohol? Yes or No

If yes, how much: ______________________________ How long? _______________________

Has anyone blood related to you ever had any type of malignancy (cancer) including leukemia? If yes, list relationship below:

____
____
____
____

Have you ever experienced any of the following? (Circle Yes or No)

EARS

Difficulty Hearing	Yes or No
Deafness	Yes or No
Buzzing/Ringing in Ears	Yes or No
Drainage from ear(s)	Yes or No

EYES

Contacts/Glasses	Yes or No
Double Vision	Yes or No
Glaucoma	Yes or No
Night Blindness	Yes or No
Cataracts	Yes or No
Pain in Eye(s)	Yes or No
Blurred Vision; not corrected by glasses	Yes or No

ENDOCRINE

Night Sweats	Yes or No
Enlarged Glands (neck or under arms)	Yes or No
Change in Scalp/Body hair	Yes or No
Poor Tolerance to heat/cold	Yes or No
Thyroid Problems	Yes or No
Abnormal Thirst	Yes or No
Hot Flashes	Yes or No

HEAD

Headaches	Yes or No
Tension	Yes or No
Migraine	Yes or No
Dizziness	Yes or No

GASTROINTESTINAL

Liver Disease	Yes or No	Yellow Jaundice	Yes or No
Heartburn (Indigestion)	Yes or No	Change in Bowel Habits	Yes or No
Excessive Gas	Yes or No	Weight Changes greater than 10 lbs in 6 months	Yes or No
Nausea	Yes or No	Trouble eating raw/greasy or spicy food	Yes or No
Vomiting Blood	Yes or No	Bloody Stool	Yes or No
Diarrhea	Yes or No	Black/Tarry Stools	Yes or No
Constipation	Yes or No	Hemorrhoids	Yes or No
Bloody Stool	Yes or No		
Mucous in Stools	Yes or No		
Gallbladder Disease	Yes or No		

HEART

Heart Murmur	Yes or No	Swelling of feet or ankles	Yes or No
Heart Attack	Yes or No	Varicose Veins	Yes or No
Anemia	Yes or No	High Blood Pressure	Yes or No
Shortness of Breath when lying flat	Yes or No	Blood Transfusions	Yes or No
Pain/Cramps in Legs	Yes or No	Poor Circulation	Yes or No
Rheumatic Fever	Yes or No	Fainting Spells	Yes or No
Chest Pain	Yes or No	Pressure Attacks	Yes or No
		Palpitations	Yes or No

MUSCULOSKELETAL

Muscle Weakness in arms or legs	Yes or No
Painful Joints	Yes or No
Swollen Joints	Yes or No
Pain/Aches in muscles	Yes or No
Gout	Yes or No
Arthritis	Yes or No

NEUROLOGICAL

Tingling/Numbness	Yes or No
Loss of Consciousness	Yes or No
Tremors/Shakes	Yes or No
Paralysis	Yes or No
Loss of Coordination	Yes or No
Balance Difficulties	Yes or No
Stroke	Yes or No
Speech Difficulties	Yes or No

LUNG

Bronchitis	Yes or No
Emphysema	Yes or No
Tuberculosis	Yes or No
Pleurisy	Yes or No
Wheezing	Yes or No
Asthma	Yes or No

SINUSES

Nose Bleeds	Yes or No
Sinusitis	Yes or No
Post Nasal Drip	Yes or No
Difficulty Swallowing	Yes or No
Dentures	Yes or No
Gum Disease	Yes or No
Dental Cavities	Yes or No

GENITOURINARY

Kidney Infection	Yes or No
Bladder Infection	Yes or No
Pain or Burning During Urination	Yes or No
Blood in Urine	Yes or No
Cloudy Urine	Yes or No
Kidney Stone	Yes or No
Gonorrhea	Yes or No
Syphilis	Yes or No
Difficulty Controlling Urine	Yes or No
Getting up to Urinate at Night	Yes or No

SKIN

Skin Cancer	Yes or No
Rash	Yes or No

List any other abnormalities:

____

____

____

____

____

MEN ONLY

Prostate Trouble	Yes or No
Discharge from Penis	Yes or No
Change in size of testicles	Yes or No
Testicular Pain	Yes or No
Difficulty having Erections	Yes or No
Breast Lump	Yes or No

WOMEN ONLY

Menstrual Cycle: Age of Onset ___________ Regular? Yes or No

Usual Duration _______________ Heavy Medium Light

Any Cramps? Yes or No

Date of Last Menstrual Cycle: _____________________ **Birth Control Pill:** Yes or No

Is Intercourse Painful? Yes or No **Number of Pregnancies:** _________

Number of Live Births: ____________ **Number of Still Births:** __________

Number of Premature Births: _____________ **Number of C-Sections:** __________

Number of Miscarriages: ______________

Any Complications?

____

____

____

Are you Pregnant Now? Yes or No **Tubal Ligation?** Yes or No

REVIEWED BY: ____

DATE: ______________________________________ **TIME:** ________________________

The information collected below is used strictly to evaluate marketing strategies.

How did you initially hear about Oklahoma CyberKnife? (Mark One Only)

Physician ___________ Physician Name: ______________________________

Television ___________ Channel: ____________________________________

Internet ___________ What led you to our website? _________________

____

Billboard ___________ Location: ____________________________________

Printed Ad ___________ Name of Publication: _________________________

Family/Friend ___________ Name: ______________________________________

News Story/Article ___________ Name of Publication: _________________________

Mall Banner @ Woodland Hills ___________

What other places have you seen marketing related to Oklahoma CyberKnife? (mark all that apply)

Television ___________ Billboard ___________

Internet ___________ Printed Ad ___________

Radio ___________ Family/Friend ___________

News Story/Article ___________ Other (elaborate) ___________________________

Mall Banner @ Woodland Hills ___________

Who is your primary care physician? ____

Patient Name: ________________________________ **Date:** ___________________________