PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

Patient Demographics	Emergency Contact Information
Name: _____ **Address:** _____ _____ _____ **Phone: mobile:** _____ **home:** _____ **E-mail address:**_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Race:** ☐ White ☐ Black/African American ☐Asian ☐ American Indian/Alaska Native ☐ Native Pacific Islander ☐ Other:_____	**Name:** _____ **Phone: mobile:** _____ **home:** _____ **Relationship to patient:** _____
	Physician Information
	Referring Physician: _____ **Primary Care Physician:** _____ **Other Treating Physicians:** _____

Past Medical History *(please list any past medical history such as hypertension, etc.):*	**Past Surgical History** *Please list all operations and dates:*

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

Family History	Please indicate if any relatives listed to the left are ***DECEASED***, include age and cause of death		
Parents:	**Relative**	**Age at death**	**Cause of Death (if known)**
Mother: Age_____ or deceased ☐			
Father: Age_____ or deceased ☐			
Full Siblings:			
# Brothers: _____ Ages:_____/_____/_____/_____			
# Sisters: _____ Ages:_____/_____/_____/_____			
Children:			
# Male: _____ Ages:_____/_____/_____/_____			
# Female: _____ Ages:_____/_____/_____/_____			

Family Medical History

(if answer "YES", please indicate which family member)

Cancer: ☐ Yes ☐ No If yes, indicate type: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Blood Disorder (non-malignant)**:** ☐ Yes ☐ No If yes, indicate type: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Diabetes: ☐ Yes ☐ No
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Heart Disease: ☐ Yes ☐ No If yes, please describe: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Stroke (before age 50): ☐ Yes ☐ No
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Mental Health Problems: ☐ Yes ☐ No If yes, indicate type: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Drug/Alcohol Problems: ☐ Yes ☐ No If yes, please describe: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Neurological disorder: ☐ Yes ☐ No If yes, indicate type: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Autoimmune disease: ☐ Yes ☐ No If yes, indicate type: _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Other: ☐ Yes ☐ No If yes, what : _____
☐ Father ☐ Mother ☐ Brother(s) ☐ Sister(s) ☐ Father's father ☐ Father's mother ☐ Mother's father
☐ Mother's mother ☐ Extended family

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

SOCIAL HISTORY	YES	NO	PAST	CURRENT
Have you ever used tobacco? If yes, how often? _____				
Do you drink alcohol? If yes, how often? _____				
Have you been treated for drug or alcohol addiction? If yes, what type of drug/s? _____				
Have you ever smoked or consumed marijuana? If yes, last time marijuana used/consumed?_____				
Have you ever injected drugs, steroids, or any medications not prescribed by a doctor?				
Employment Status: □ Full-Time □ Part- Time □ Unemployed □ Retired				
Occupation: _____				
Marital Status: □ Single □ Married □ Separated □ Divorced				

LEARNING AND EDUCATION:

Are there any (check all that apply)?:

Cultural social/spiritual barriers to learning about your condition or procedure? ☐ Yes ☐ No

Physical barriers to learning about your condition or procedure? ☐ Yes ☐ No

I want to learn more about my medical condition or procedure. ☐ Yes ☐ No

Highest level of education achieved: _____

How do you learn best? □ Verbal □ Demonstration □ Written □ Visual

VACCINATION HISTORY:

Date of last Tetanus: _____/_____/_____	☐ unknown	☐ not received	
Date of last Pneumovax: _____/_____/_____	☐ unknown	☐ not received	
Date of last Influenza: _____/_____/_____	☐ unknown	☐ not received	
Date of last Pertussis: _____/_____/_____	☐ unknown	☐ not received	
Date of HPV: _____/_____/_____	☐ unknown	☐ not received	
Date of shingles: _____/_____/_____	☐ unknown	☐ not received	
Date of Varicella Zoster (chickenpox): _____/_____/_____	☐ unknown	☐ not received	☐ had chickenpox infection

ROUTINE HEALTH SCREENINGS:

Colonoscopy: _____/_____/_____	☐ unknown	
Mammogram: _____/_____/_____	☐ unknown	☐ not applicable
Pap smear: _____/_____/_____	☐ unknown	☐ not applicable, **male** patient/donor
Prostate Specific Antigen (PSA): _____/_____/_____	☐ unknown	☐ not applicable, **female** patient/donor

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

Allergies/Adverse Reactions *Please include all allergies: food, latex, medications and seasonal. List allergy and specific reaction.*	

Medications *Please list all current medications including all over the counter medications, vitamins and herbal supplements. If pain medication, please list provider prescribing it.*	

Instructions:

Do you have now, or have you ever had the diseases or conditions listed below?
(You must check Yes, No or write in answer, do not leave any blank! Also indicate if it is a past or current condition.)
If you answer Yes to any questions, please give an explanation in the Comments section at the end of this document.

GENERAL	YES	NO	PAST	CURRENT
Have you ever had any problems with anesthesia?				
Chronic fatigue				
Unintentional weight loss/gain				
Sweats				
Have you ever been diagnosed with any type of cancer? If YES, what type? _____				

EAR/NOSE/THROAT	YES	NO	PAST	CURRENT	EAR/NOSE/THROAT	YES	NO	PAST	CURRENT
Loss of hearing					Sinus pain				
Seasonal allergies					Ringing in the ears				
Nose bleeds					Dental problems				
Chronic hoarseness					Dizziness				
Ear infection									

EYES	YES	NO	PAST	CURRENT	EYES	YES	NO	PAST	CURRENT
Blurred vision					Glaucoma				
Double vision					Cataract				
Loss of vision					Eye disease				
Chronic hoarseness					Dizziness				

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

Reviewed by coordinator/navigator: _____

CARDIOVASCULAR	YES	NO	PAST	CURRENT	CARDIOVASCULAR	YES	NO	PAST	CURRENT
High blood pressure					Ankle or leg swelling				
Heart murmur					Blood clots legs/heart/lungs				
Rheumatic fever					Heart disease				
Abnormal EKG					Difficulty walking or climbing stairs				
Abnormal exercise treadmill test					Trouble breathing when lying flat				
Angina/chest pain/chest pressure					Wake up short of breath				
Heart attack					Fainting				
Palpitations/irregular heartbeats					Other heart disease, specify:				
Pain in the leg(s) with walking									

RESPIRATORY	YES	NO	PAST	CURRENT	RESPIRATORY	YES	NO	PAST	CURRENT
Tuberculosis (TB)					Frequent cough				
Positive skin test for TB					Chronic or recurrent bronchitis				
Asthma or wheezing					Emphysema ***or*** COPD (Chronic Obstructive Pulmonary Disease)				
Do you have sleep apnea?					Do you currently use oxygen? If yes, how much? ___ Liters Per Minute				
Lung surgery					Do you use a CPAP (Continuous Positive Airway Pressure) machine?				

GASTROINTESTINAL	YES	NO	PAST	CURRENT	GASTROINTESTINAL	YES	NO	PAST	CURRENT
Loss of bowel control					Diverticulitis				
Heartburn					Frequent nausea/upset stomach/vomiting				
Hiatal hernia					Frequent diarrhea				
Ulcer					Frequent or chronic constipation				
Liver disease					Any type of abdominal surgery				
Hepatitis					Frequent abdominal pain				
Polyps or tumors of the bowel					Blood in the bowel movements				
Gall Stones									

GENITOURINARY	YES	NO	PAST	CURRENT	GENITOURINARY	YES	NO	PAST	CURRENT
Kidney disease					Burning on urination				
Kidney stones					Frequent urination at night				
Kidney infection					Inability to empty bladder				
Bladder infection					Blood in urine				
Loss of bladder control					Enlarged prostate				

ENDOCRINE	YES	NO	PAST	CURRENT	ENDOCRINE	YES	NO	PAST	CURRENT
Diabetes					Heat intolerance				
Thyroid disease					Cold intolerance				

DERMATOLOGY	YES	NO	PAST	CURRENT	DERMATOLOGY	YES	NO	PAST	CURRENT
Rash					Hair loss				
Chronic skin sores					Nail changes				
Skin cancer					Itching				

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

NEUROLOGY	YES	NO	PAST	CURRENT	NEUROLOGY	YES	NO	PAST	CURRENT
Headache					Dizziness				
Migraine headaches					Unsteady gait				
Stroke/TIA(transient ischemic attack)					Difficulty speaking				
Seizures					Arm or leg that goes numb/weak				
Memory loss					Nerve paralysis				

MUSCULOSKELETAL	YES	NO	PAST	CURRENT	MUSCULOSKELETAL	YES	NO	PAST	CURRENT
Leg cramps					Joint pain				
Painful muscles					Joint stiffness				
Sciatica					Broken bone				
Back pain/problems					Osteoporosis				
Neck pain/problems					Arthritis				
Gout					Surgery of the neck/back or joints				

HEMATOLOGY	YES	NO	PAST	CURRENT	HEMATOLOGY	YES	NO	PAST	CURRENT
Easy bruising					Enlarged spleen				
Bleeding					Tested positive for HIV/AIDS				
Enlarged lymph nodes					Babesiosis (Babesia species infection)				
Malaria					Chagas disease (Trypanosoma cruzi infection)				
Transfusions (Red blood cells, platelets, plasma)									

AUTOIMMUNE DISEASES	YES	NO	PAST	CURRENT	AUTOIMMUNE DISEASES	YES	NO	PAST	CURRENT
Rheumatoid arthritis					Multiple sclerosis				
Systemic lupus erythematosus									

MENTAL HEALTH	YES	NO	PAST	CURRENT
Have you ever received therapy/counseling?				
Have you ever been hospitalized for emotional reasons?				
Do you have depression?				
Do you have anxiety?				
Have you ever been treated with an antidepressant or anti-anxiety medication?				
Have you ever been treated with medications for other mental health issues?				
Have you ever been treated for substance abuse?				
Are there major problems or conflicts at work/home?				

NUTRITION	YES	NO	PAST	CURRENT	NUTRITION	YES	NO	PAST	CURRENT
Inability to eat					Swallowing difficulties or chewing problems				
Unintentional weight loss					Special requirements for your: kidneys/liver/heart/diabetes				
Unintentional weight gain					Do you have any questions about how your diet may impact your current health/medical condition?				
Are you pregnant or lactating									

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

SEXUALITY/REPRODUCTION	YES	NO	PAST	CURRENT
Change in sexual function				
Difficulty with Intercourse				
Are you concerned about your fertility?				
Would you like more information on how your fertility can be managed during treatment?				
Sexually Transmitted Disease: If Yes, (Circle all that apply): HIV ☐ Syphilis ☐ Chlamydia ☐ HPV (genital warts) ☐ Gonorrhea ☐				
Current Method of Contraception (Circle all that Apply): None ☐ Oral Contraceptive ☐ IUD ☐ Condoms ☐ Sterilization ☐ Diaphragm ☐ Withdrawal ☐				

FEMALES ONLY	YES	NO	PAST	CURRENT
Age at first menstrual cycle:				
Have you been pregnant in the past 6 weeks or are you pregnant now?				
Number of pregnancies:				
Number of Live Births:				
Have you gone through menopause (no menstruation for more than 12 months)?				

TRAVEL:

In the past **3 years** have you ***lived*** (greater than 12 months) outside the United States or Canada? ☐ Yes ☐ No

In the past **12 months** have you ***traveled*** outside the United States or Canada? ☐ Yes ☐ No

ADVANCE DIRECTIVES:

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Medical Power of Attorney? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No

Comments *(explain any YES answers)*

_____

_____

_____

_____

_____

_____

_____

Reviewed by coordinator/navigator: _____

PSLMC/Colorado Blood Cancer Institute
HEALTH HISTORY QUESTIONNAIRE

I confirm that all information provided is true and accurate to the best of my knowledge.

Initial patient/donor work-up:

Reviewed by: _____ **Date:** _____ **Time:** _____
Patient Signature

Reviewed by: _____ **Date:** _____ **Time:** _____
Physician Signature

Reviewed by: _____ **Date:** _____ **Time:** _____
Navigator/Coordinator Signature

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Authorization to Release Medical Records from: _____

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I. My Authorization

You may release my complete medical record (check all that applies):

- ☐ All my health information maintained by the above named practice
  (Circle *Include or Exclude* for each of the following)
  - ☐ Include or Exclude: ☐ My health information related to drug use
  - ☐ Include or Exclude: ☐ My health information related to alcohol abuse
  - ☐ Include or Exclude: ☐ My health information related to HIV / AIDS
  - ☐ Include or Exclude: ☐ My health information related to psychological or psychiatric conditions, including psychotherapy notes
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

You may release information to:

Address

Fax

Reason for this authorization:

- ☐ At my request

This authorization ends:

- ☐ on (date) _____
- ☐ This authorization will remain in effect until notice of cancellation.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter to the office.

Colorado Blood Cancer Institute will release records to the above provider. Upon receipt of those records, the provider or organization assumes responsibility for the security of those copied records.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian,personal representative, etc.)

CBCI
COLORADO BLOOD CANCER INSTITUTE
AT PRESBYTERIAN/ST LUKE'S

Authorization to Release Medical Records

Patient Information/Label

Patient Name: _____ **Pharmacy Name:** _____

Please print

Phone Number: _____

Please list all medications you are currently taking, *including* over the counter medications and herbal remedies.

Medication:	Dosage:	Directions:	Reason for taking:	Ordering Dr.

CBCI
COLORADO BLOOD CANCER INSTITUTE
AT PRESBYTERIAN/ST. LUKE'S

Medication List

Patient Information/Label

21-7334 (10/10)

QUESTIONS

Dear Patient,

As you prepare for your visit to Colorado Blood Cancer Institute, you may have many thoughts and questions. At home, you may think of a million things you need to ask, but then seem to draw a blank when you are in the office. Please use this form to jot down questions, as you think of them, to ask the physician, nurses, or staff at the time of your visit.

CBCI
COLORADO BLOOD CANCER INSTITUTE
AT PRESBYTERIAN/ST LUKE'S

Questions

Patient Information/Label

CBCI
COLORADO BLOOD CANCER INSTITUTE
AT PRESBYTERIAN/ST.LUKE'S

PHYSICIANS
Scott Bearman
Mark Brunvand
Alireza Eghtedar
Tara Gregory
Michael Maris
Jeffrey Matous
Peter McSweeney
Richard Nash
Michael Tees

ADVANCE PRACTICE PROVIDERS
Megan Andersen NP-C
Courtney Bryan PA-C
Alison Collings NP-C
Kristy Connor FNP-C
Andrea Doberstein PA-C
Ryan Fallt PA-C
Sarah Mann NP-C
Devin Nelson PA-C
Margaret Profita PA-C
Monica Schlatter NP-C
Diana Vucurevich NP-C
Bryce Younger PA-C

Ph 720-754-4800
Fx 866-341-6984

1721 East 19th Ave
Suite 300
Denver, CO 80218

www.bloodcancerinstitute.com

CBCI Clinic Information

The CBCI Clinic is located in the Professional Plaza East Building of Presbyterian/St. Lukes (PSL) Medical Center in Suite 200, second floor and Suite 300, third floor. We sit directly East of the main entrance to the hospital. Please review the following information regarding our office. If you have any questions regarding these items, please don't hesitate to call the office.

Parking:
Presbyterian St. Luke's Medical Center is a large campus. The following convenient parking options are available for CBCI patients and families. Please refer to the parking map.

- Free Valet Parking near the main entrance of PSL. You can pull up to the valet parking station and walk into the PPE entrance. There is an elevator in the lobby that will take you to the second or third floor. Wheelchairs are available in the main lobby of PSL. The valet parking service is provide at no charge. It is up to your discretion if you choose to provide a gratutity/tip if you believe you received excellent service by the valet team.
- Free CBCI Designated Parking in the Professional Plaza East Parking Garage. This above-ground parking garage is located at Williams Street and 19th Avenue. There are parking spaces designed for CBCI patients on the lower and upper sides of the second level. There is a covered walkway/bridge on the second level that goes directly to the second floor of the CBCI clinic as well as the elevator to take you to the third floor.
- Free parking in the PSL underground garage that can be accessed from the main driveway of PSL.
- Free on-street parking in limited to two hours.
- Free surface lot parking between 18th and 19th Avenues and Williams and Gilpin Streets.

Please allow extra time to find parking and locate the clinic for this visit. Call our main clinic number if you have any questions at 720-754-4800.

Warm Regards,
CBCI Team

Colorado Blood Cancer Institute Co-Pay and Referral Policy

The Colorado Blood Cancer Institute at Presbyterian/St. Luke's Medical Center participates with many insurance companies. As a courtesy to our patients, we will bill your insurance for all visits to our clinic.

Our billing policies and insurance contract agreements require that we collect all co-pays at the time of service.

Your insurance company may require a referral from your primary care provider (PCP) prior to your visit to our clinic. If this is the case, please make sure that your PCP initiates the referral process and forwards that referral to our office prior to your scheduled appointment. If we do not have a valid referral in place, we will bill the visit directly to you.

If you are uninsured, we offer a 35% discount on all services provided by our office and will require a deposit or "good faith payment" at the time of service. Please be advised that additional services (labs, scans, etc.) by other providers may be required in the course of your treatment, and are not included in the 35% discounted rates.

If you are unable to pay at the time of service, you will need to meet with our Patient Financial Counselors to set up a payment plan.

I understand this policy and accept the terms.

Patient Name: _____

Patient Signature: _____ Date: _____

CBCI
COLORADO BLOOD CANCER INSTITUTE
AT PRESBYTERIAN/ST. LUKE'S

Disability/Family Medical Leave Checklist

****Please allow 10 business days for completion of paperwork****

Date of Request: _____ Patient Name: _____

Patient Date of Birth: _____ Contact Phone Number: _____

Anticipated Start Date of Disability/FMLA: _____

Did the patient have a transplant: YES ☐ NO ☐ AUTO ☐ ALLO ☐

Date of Procedure: _____ CBCI Physician: _____

When complete, a copy of all Disability/FMLA paperwork will be kept on file as part of the permanent medical record. If additional copies are requested, please complete the following:

- Copy mailed or faxed to Disability/FMLA Insurance Company? YES ☐ NO ☐
- Company Name/Fax Number: _____
- Additional copy to patient? YES ☐ NO ☐
- Current mailing address: _____

If you do not have the forms and need to have your insurance company fax them to our office, please provide them with the following information:

Paperwork must be faxed to: 866-669-6506 Attn: Lisa Dowd

Please direct all questions to: 720-754-4836 (telephone inquiries) or email to Lisa.Dowd@healthonecares.com

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To be completed by CBCI Staff

Assigned to: Charge Nurse ☐ Navigator ☐ Transplant Coordinator ☐

Date completed: _____

Please attach this form to the front page of the Disability/FMLA Paperwork