

**PSLMC/Colorado Blood Cancer Institute  
HEALTH HISTORY QUESTIONNAIRE**

Patient Demographics	Emergency Contact Information
<b>Name:</b> _____ <b>Address:</b> _____ _____ _____ <b>Phone: mobile:</b> _____ <b>home:</b> _____ <b>E-mail address:</b> _____ <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Pacific Islander <input type="checkbox"/> Other: _____	<b>Name:</b> _____ <b>Phone: mobile:</b> _____ <b>home:</b> _____ <b>Relationship to patient:</b> _____ <hr/> <div style="text-align: center; background-color: #e0e0e0;"><b>Physician Information</b></div> <b>Referring Physician:</b> _____ <b>Primary Care Physician:</b> _____ <b>Other Treating Physicians:</b> _____

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

Reviewed by coordinator/navigator: \_\_\_\_\_



**Health History  
Questionnaire**  
 CBCI F2-PE 01.010/020  
 4/18/2016

(PATIENT LABEL)



## PSLMC/Colorado Blood Cancer Institute HEALTH HISTORY QUESTIONNAIRE

Family History	Please indicate if any relatives listed to the left are <u>DECEASED</u> , include age and cause of death		
Parents:	Relative	Age at death	Cause of Death (if known)
Mother: Age _____ or deceased <input type="checkbox"/>			
Father: Age _____ or deceased <input type="checkbox"/>			
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: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired				
Occupation: _____				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> 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

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

<b>Medications</b>	
<i>Please list all current medications including all over the counter medications, vitamins and herbal supplements. If pain medication, please list provider prescribing it.</i>	

**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				



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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 <u>or</u> 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: \_\_\_\_\_



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## 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: \_\_\_\_\_



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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)*

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Reviewed by coordinator/navigator: \_\_\_\_\_



**PSLMC/Colorado Blood Cancer Institute  
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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.)



**Authorization to Release  
Medical Records**

**Patient Information/Label**





## 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.

### PHYSICIANS

Scott Bearman

Mark Brunvand

Alireza Eghtedar

Tara Gregory

Michael Maris

Jeffrey Matous

Peter McSweeney

Richard Nash

Michael Tees

### 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 gratuity/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 19<sup>th</sup> 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 18<sup>th</sup> and 19<sup>th</sup> 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

### 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





## 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: \_\_\_\_\_



## 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](mailto: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\*\***