

Virginia G. Piper Cancer Care Network

Welcome to the HonorHealth Virginia G. Piper Cancer Care Network.

We understand how challenging the diagnosis of a blood or bone marrow disorder can be and are committed to helping you every step of the way. Our valley-wide locations for hematology care, puts you, the patient, at the center of everything we do. We are here to support you and your family through diagnosis, treatment, and survivorship.

Because hematological disorders can have many different forms, our team of experts will provide you with extensive resources as a coordinated care team, all available within our network. These services may include:

- Imaging
- Laboratory
- Pathology
- Genetic counseling
- Surgery
- Patient navigation
- Mind, body and spirit programs
- Palliative care
- Nutritional support
- Social work services
- Clinical trials
- Interpreter services
- Symptom management
- Financial counseling
- Exercise physiology
- Physical, occupational and lymphedema therapy

The doctors, nurses and caregivers in the HonorHealth Virginia G. Piper Cancer Care Network look forward to providing you with outstanding hematologic care.

If you have questions, please do not hesitate to talk to your physician. You may also call 855-485-HOPE (4673) for additional medical hematology support.

It is an honor to serve you during this time.

Patient Full Name: _____ Birth Date: _____

SSN: _____ Email Address: _____ Gender: ☐ M ☐ FHome Address: _____
Street City State ZipMailing Address: _____
Street City State Zip

Home Phone: _____ Work phone: _____

Mobile Phone: _____ Mobile Phone Provider: _____

Notification preference? ☐ Mobile Phone ☐ e-Mail ☐ Text Message ☐ Home Phone

May we leave a message (circle)? Yes or No Please circle preference for voice message: Home or Mobile Phone

Mothers Maiden Name: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ WidowedEthnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino (requested demographic question for the State of AZ)Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ White/Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Religion Preference: _____

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other: _____Visually Impaired: ☐ Yes ☐ No

Patient Employer: _____ Occupation: _____

Primary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group#: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group#: _____

Do you have a Living Will? ☐ Yes ☐ No
Do you have a DNR? ☐ Yes ☐ NoIf yes, please provide a copy for our records
If yes, please provide a copy for our records

Visit Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ When did the problem begin: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE #) _____

PRIMARY DOCTOR (NAME, ADDRESS, PHONE #) _____

PATIENT'S PHARMACY (NAME, ADDRESS, PHONE #) _____

MEDICINE/FOOD/LATEX/CONTRAST ALLERGIES: _____ NONE or LIST IF ANY: _____

CURRENT MEDICATIONS (name and dosage) OR **CHECK HERE** _____ if Med List is attached

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

CHRONIC CONDITIONS/PAST MEDICAL HISTORY: Have you ever had any of the following? (circle all that apply)

High Blood Pressure
 Diabetes – If yes, type: _____
 Stroke/TIA
 Lupus
 Heart Failure
 Vascular Disease
 Heart Disease
 Heart attack
 Seizures
 Colitis/Diverticulitis
 Anxiety
 Depression

COPD
 Hyperthyroidism
 Abnormal Heart Rhythm
 Atrial Fibrillation
 Heart Murmur
 Neuropathy
 Hypothyroidism
 Aneurysm
 Blood Clots
 Genetic Disorder Type: _____
 STDs - If yes, type: _____
 HIV
 Other: _____

Have you had any of the following tests?

	Yes	When and Where
Abnormal biopsy	☐	
CT Scan	☐	
MRI Scan	☐	
PET Scan	☐	
Mammogram	☐	
Colonoscopy	☐	
PAP Smear	☐	
Endoscopy	☐	
Blood Transfusions	☐	
Bone Mineral Density Test (DEXA)	☐	

Patient Name: _____ Date of Birth: _____

PATIENT SURGICAL HISTORY (NAME AND YEAR)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Any implanted devices or metal (pacemakers, pumps, etc.) Please circle: **YES** **NO****VACCINES:** Have you had the following vaccines:

PNEUMONIA	☐ NO	☐ YES, Date _____	TETANUS	☐ NO	☐ YES, Date _____
SHINGLES	☐ NO	☐ YES, Date _____	FLU VACCINE	☐ NO	☐ YES, Date _____
OTHER VACCINE	☐ NO	☐ YES, Date _____			

TOBACCO USE: ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **ALCOHOL USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY**CAFFEINE** (Coffee, tea, energy drinks) ☐ NEVER ☐ RARELY ☐ DAILY**DRUG USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **EXPOSURE TO HIV:** ☐ NO ☐ YES**SOCIAL HISTORY: Lifestyle**

Highest Education level: _____

With whom do you live? _____

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes, 3x/week or moreHave you experienced 10 lbs weight loss or gain in past 3 months? ☐ NO ☐ YES**SOCIAL HISTORY: Mobility**Do you have problems with mobility (use a wheelchair, cane, or walker)? ☐ NO ☐ YES; if yes describe issue and/or device used: _____Have you had a fall in the past year? ☐ NO ☐ YESDo you feel unsteady? ☐ NO ☐ YES**FAMILY MEDICAL HISTORY****ALIVE AND WELL?****DISEASE****IF DECEASED, CAUSE AND AGE OF DEATH**FATHER ☐ NO ☐ YES _____MOTHER ☐ NO ☐ YES _____

Any history of cancer in the family? _____

Are there any religious considerations that would keep you from receiving blood products? ☐ NO ☐ YES**Women only ---****Age menstrual cycle began:** _____ **Menopause Age:** _____ **Number of Pregnancies:** _____ **Live Births:** _____

CONSTITUTIONAL SYMPTOMS			EYES CONTINUED		
ACTIVITY CHANGE	NO	YES	EYE REDNESS (DRY EYES)	NO	YES
APPETITE CHANGE	NO	YES	FLOATERS	NO	YES
CHILLS	NO	YES	PHOTOPHOBIA (SENSITIVITY TO LIGHT)	NO	YES
DIAPHORESIS (SWEATING)	NO	YES	VISUAL DISTURBANCE	NO	YES
FATIGUE (WEAKNESS)	NO	YES	RESPIRATORY		
FEVER	NO	YES	DYSPNEA ON EXERTION (SHORTNESS OF BREATH ON EXERTION)	NO	YES
NIGHT SWEATS	NO	YES	CHEST TIGHTNESS	NO	YES
PAIN	NO	YES	CHOKING	NO	YES
RIGORS (CHILLS)	NO	YES	COUGH	NO	YES
UNEXPECTED WEIGHT CHANGE	NO	YES	HEMOPTYSIS(COUGHING UP BLOOD)	NO	YES
HEENT			SHORTNESS OF BREATH (DIFFICULTY BREATHING)	NO	YES
CONGESTION	NO	YES	STRIDOR	NO	YES
DENTAL PROBLEM	NO	YES	WHEEZING (ASTHMA)	NO	YES
DRY MOUTH	NO	YES	CARDIOVASCULAR		
EAR PAIN	NO	YES	CHEST PAIN	NO	YES
FACIAL SWELLING	NO	YES	LEG SWELLING	NO	YES
HAIR LOSS	NO	YES	ORTHOPNEA	NO	YES
HEARING LOSS	NO	YES	PALPITATIONS	NO	YES
MOUTH SORES	NO	YES	PND(PAROXYSMAL NOCTURNAL DYSPNEA)	NO	YES
NOSEBLEEDS	NO	YES	GI		
POSTNASAL DRIP	NO	YES	ABDONIMAL DISTENTION	NO	YES
RHINORRHEA (RUNNY NOSE)	NO	YES	ABDOMINAL PAIN	NO	YES
SINUS PRESSURE	NO	YES	ANAL BLEEDING	NO	YES
SORE THROAT	NO	YES	ASCITES (ABDOMINAL SWELLING)	NO	YES
TASTE CHANGES	NO	YES	BLOOD IN STOOL (BLACK STOOLS)	NO	YES
THRUSH	NO	YES	CONSTIPATION	NO	YES
TINNITUS (RINGING IN EARS)	NO	YES	DIARRHEA	NO	YES
TROUBLE SWALLOWING	NO	YES	EARLY SATIETY (FEELING FULL)	NO	YES
VOICE CHANGE	NO	YES	GERD/HEARTBURN	NO	YES
BREAST			NAUSEA AND VOMITING	NO	YES
RIGHT INVERTED NIPPLE	NO	YES	HERNIA	NO	YES
RIGHT MASS	NO	YES	ENDOCRINE		
RIGHT NIPPLE DISCHARGE	NO	YES	COLD INTOLERANCE	NO	YES
RIGHT SKIN CHANGE	NO	YES	DIABETES	NO	YES
LEFT INVERTED NIPPLE	NO	YES	HEAT INTOLERANCE	NO	YES
LEFT MASS	NO	YES	HOT FLASHES	NO	YES
LEFT NIPPLE DISCHARGE	NO	YES	POLYDIPSIA (GREAT THIRST)	NO	YES
LEFT SKIN CHANGE	NO	YES	POLYPHAGIA (EXCESSIVE EATING)	NO	YES
EYES			POLYURIA (EXCESSIVE URINATION)	NO	YES
BLURRED VISION	NO	YES	PRE-DIABETES	NO	YES
DOUBLE VISION	NO	YES	GU		
EYE DISCHARGE	NO	YES	DYSURIA((PAIN/DIFFICULTY URINATING, HESITANCY)	NO	YES
EYE ITCHING	NO	YES			
EYE PAIN	NO	YES	FLANK PAIN	NO	YES

GU CONTINUED			PSYCHIATRIC		
FREQUENT URINATION	NO	YES	AGITATION	NO	YES
HEMATURIA (BLOOD IN URINE)	NO	YES	BEHAVIOR PROBLEM	NO	YES
INCONTINENCE	NO	YES	CONFUSION	NO	YES
NOCTURIA (FREQUENT URINATION AT NIGHT)	NO	YES	DECREASED CONCENTRATION	NO	YES
PENILE DISCHARGE	NO	YES	DEPRESSION	NO	YES
PENILE PAIN	NO	YES	HALLUCINATIONS	NO	YES
PENILE SWELLING	NO	YES	HYPERACTIVE	NO	YES
SCROTAL SWELLING	NO	YES	NERVOUS/ANXIOUS (PANIC ATTACKS)	NO	YES
TESTICULAR PAIN	NO	YES	SELF-INJURY	NO	YES
URGENCY TO URINATE	NO	YES	SLEEP DISTURBANCE (INSOMNIA)	NO	YES
DECREASED URINE	NO	YES	SUICIDAL IDEAS	NO	YES
MUSCULOSKELETAL			HOMICIDAL IDEAS		
ARTHRALGIAS (JOINT PAIN/BONE PAIN)	NO	YES	GYN		
BACK PAIN	NO	YES	VAGINAL DISCHARGE	NO	YES
GAIT PROBLEM (WALKING ABNORMALLY)	NO	YES	VAGINAL PAIN	NO	YES
JOINT SWELLING	NO	YES	ABNORMAL BLEEDING	NO	YES
MYALGIAS (MUSCLE PAIN)	NO	YES			
NECK PAIN	NO	YES			
NECK STIFFNESS	NO	YES			
SKIN					
BLISTERING	NO	YES			
CHANGING MOLES (SKIN LESIONS)	NO	YES			
COLOR CHANGE	NO	YES			
ALLERGY/IMMUNE SYSTEM					
ENVIRONMENTAL/SEASONAL ALLERGIES	NO	YES			
FOOD ALLERGIES	NO	YES			
IMMUNOCOMPROMISED	NO	YES			
CHEMICALS IN WORKPLACE	NO	YES			
NEUROLOGICAL					
PAINFUL NEUROPATHY	NO	YES			
DIZZINESS	NO	YES			
FACIAL ASYMMETRY	NO	YES			
HEADACHES	NO	YES			
LIGHT-HEADEDNESS	NO	YES			
NUMBNESS/TINGLING	NO	YES			
SEIZURES	NO	YES			
SPEECH DIFFICULTY	NO	YES			
SYNCOPE (ALTERED CONSCIOUSNESS)	NO	YES			
TREMORS	NO	YES			
WEAKNESS (PARALYSIS)	NO	YES			
HEMATOLOGIC					
ADENOPATHY (ENLARGED GLANDS)	NO	YES			
BRUISES/BLEEDS EASILY	NO	YES			
LYMPHEDEMA	NO	YES			
PETECHIAE (BLEEDING UNDER SKIN)	NO	YES			
PURPURA (RASH)	NO	YES			

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Healthcare Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒ Y ☐ N	EXAMPLE BREAST CANCER	45	—	—	Aunt Cousin	45 51	Grandmother	53
☐ Y ☐ N	BREAST CANCER (Female or Male)							
☐ Y ☐ N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
☐ Y ☐ N	UTERINE (ENDOMETRIAL) CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME GASTROINTESTINAL POLYPS (Specify #)							
☐ Y ☐ N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						
☐ Y ☐ N	Are you of Ashkenazi Jewish descent?							
☐ Y ☐ N	Are you concerned about your personal and/or family history of cancer?							
☐ Y ☐ N	Have you or anyone in your family had generic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)							

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any of the following:

☐	Multiple A combination of cancers on the same side of the family:	☐ 2 or more: breast / ovarian / prostate / pancreatic cancer ☐ 2 or more: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ☐ 2 or more: melanoma / pancreatic
☐	Young Any 1 of the following at age 50 or younger :	☐ Breast cancer ☐ Colorectal cancer ☐ Endometrial cancer
☐	Rare Any 1 of these rare presentations at any age :	☐ Ovarian cancer ☐ Breast: Male breast cancer or Triple negative breast cancer ☐ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology ^{††} ☐ Endometrial cancer with abnormal MSI/IHC ☐ 10 or more gastrointestinal polyps*

^{††} Presence of tumor infiltrating lymphocytes, Crohn's-lick lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern * Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature _____ Date: _____
 Healthcare Provider's Signature: _____ Date: _____

For Office Use only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
 Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment _____

**Notice of Privacy Practices and
Communication Consent**

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends with whom Virginia G. Piper Cancer Care Network can share your protected health information.

Name	Phone Number	Relationship

I _____ acknowledge that I have received a copy of Virginia G. Piper Cancer Care Network's Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Virginia G. Piper Cancer Care Network. I understand that this release is valid for the time frame of my diagnosis, but may revoke authorization at any time by informing Virginia G. Piper Cancer Care Network specialists and my physician.

Print Name: _____

Date: _____

Patient Signature: _____