



Self-Reported History Form – LUNG SCREENING

Date Form Completed: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____

Marital Status: Single Married Divorced Widowed

Primary Doctor

Name: _____

City: _____ State: _____

Release info to this doctor? Yes No

Pharmacy Information

Preferred Pharmacy: _____

City: _____

Past Medical History - (check the box if you have been diagnosed with or have *any* of the following)

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal bleeding or bruising | <input type="checkbox"/> Fractures | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent headaches or migraines | <input type="checkbox"/> Numbness in arms/legs |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High cholesterol/triglycerides | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Blood problems (clots, anemias) | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Cancer (other/previous) | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Kidney problems/Dialysis | <input type="checkbox"/> Stroke/Paralysis |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Collagen vascular disease | <input type="checkbox"/> Swelling of ankles/feet |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Tuberculosis |

Have you **EVER** had radiation, radium, radioactive implants or cobalt treatments? Yes No
If **Yes**, at what Center(s) did you receive these treatments? _____

Do you have a pacemaker or a defibrillator or other implanted device? Yes No

Do you have an autoimmune disease like lupus or scleroderma? Yes No

Females: Are you or could you be pregnant? Yes No

Surgical History (List the types of surgery you have had and approximate date) Include any implanted devices:

Have you ever had chemotherapy? Yes No

If **Yes**, at what Center did you receive these treatments? _____

Please add the type, if know: _____

Do you have any other health issues not included above? Yes No

Please list all medications and dosages, including over the counter, supplements, and herbal medications you are taking or attach list:

Medication Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: List all medication and any other allergies and symptoms/side effects experienced:

No known allergies

Family Cancer History

Relationship to you	Type of Cancer	Age at Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you now or have you ever smoked? Yes No

Number of years you smoked: _____ If you have quit, what year? _____ Packs or cigarettes per day? _____

Smokeless tobacco? Yes No

Do you drink alcohol? _____ Yes No

If Yes, how much per week? _____

Do you have a history of drug or alcohol abuse?

Yes No

If Yes, what type? _____

Have you ever been exposed to hazardous materials?

Yes No

If Yes, what and for how long? _____

Do you have any cultural or religious beliefs that affect your medical care?

Yes No

If Yes, please describe: _____

Has your weight changed in the last 3 months?

Yes No

Have you had a Flu Vaccine this year?

Yes No

Are you in a relationship with someone who hurts or harms you?

Yes No

Do you have an Advanced Directive or Living Will?

Yes No

Do you have a "Do Not Resuscitate Order"?

Yes No

Are copies of these directives provided today?

Yes No

Review of Systems (please check any/all that apply to you)

Constitutional / General

- Fever
- Shaking/Chills
- Swelling or lumps
- Night Sweats
- Fatigue
- Sleep issues
- Weight loss/Gain

Skin, Nails, Hair

- Rashes
- Itching
- Sores or Wounds

Heart / Cardiovascular

- Chest pain
- Irregular heartbeat
- Leg swelling

ENT / Eyes Ears Nose Throat

- Nose bleeds
- Dry mouth
- Difficulty swallowing
- Mouth pain/sores
- Voice Changes
- Changes in taste/smell

Lung / Respiratory

- Cough up blood
- Shortness of breath
- Wheezing
- Chronic cough
- Home oxygen

Stomach/GI

- Abdominal pain
- Nausea or vomiting
- Constipation
- Diarrhea
- Hemorrhoids
- Clay or bloody stools
- Heartburn
- Ulcers

Urinary/GU

- Pain with urination
- Trouble starting urine
- Trouble stopping urine
- Blood in urine
- Night time urination
- Incontinence

Endocrine

- Hot flashes

- Excessive thirst or hunger
- Heat or cold intolerance
- Excessive urination

Musculoskeletal

- Limited motion
- Jerking or shaking
- Problems walking

Musculoskeletal (cont)

- Tingling or Numbness
- Paralysis
- Seizures

Psychological/ Behavioral

- Personality changes or excessive anger
- Depression
- Nervousness or anxiety
- Suicidal thoughts
- Hallucinations
- Memory problems

Neurologic:

- Headaches
- Hearing loss or ringing
- Double vision

- Visual changes or Loss
- Dizzy Spells

Hematologic / Lymphatic:

- Color Changes/Bruising
- Low blood count
- Bleeding Problems

Allergic / Immunologic:

- Difficulty breathing
- Choking due to allergies
- Face swelling

Pain

Do you have pain now?

- Yes No

If yes, where is the pain? _____

On a scale of 0-10, 0 being no pain and 10 intense, how do you rate your pain? _____

6C. Additional risk factors	
6C1. Education level	Select one: <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th – 11 th grade <input type="checkbox"/> High School Graduate or High School Equivalency <input type="checkbox"/> Post high school training, other than college (e.g. Vocational/Some Technical School) <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Graduate or Professional <input type="checkbox"/> Unknown / Refused to Answer <input type="checkbox"/> Other, please specify: _____
6C2. Radon exposure – documented high exposure levels:	<input type="checkbox"/> No <input type="checkbox"/> Yes
6C3. Occupational exposures to agents that are identified specifically as carcinogens targeting the lungs	Select all that apply: <input type="checkbox"/> Silica <input type="checkbox"/> Cadmium <input type="checkbox"/> Asbestos <input type="checkbox"/> Arsenic <input type="checkbox"/> Beryllium <input type="checkbox"/> Chromium <input type="checkbox"/> Diesel fumes <input type="checkbox"/> Nickel <input type="checkbox"/> Other, Please specify: _____
6C4. History of cancers that are associated with an increased risk of developing a new primary lung cancer	Select all that apply: <input type="checkbox"/> Prior lung cancer <input type="checkbox"/> Lymphoma <input type="checkbox"/> Head and Neck Cancer <input type="checkbox"/> Bladder <input type="checkbox"/> Other smoking-related cancers, please specify: _____
6C5. Lung cancer in first-degree relative (mother, father, sister, brother, daughter, or son with history of lung cancer):	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure / Unknown
6C6. Family history of lung cancer, other than first-degree relative:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure / Unknown
6C7. COPD:	<input type="checkbox"/> No <input type="checkbox"/> Yes
6C8. Pulmonary fibrosis:	<input type="checkbox"/> No <input type="checkbox"/> Yes
6C9. Secondhand smoke exposure:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure / Unknown

Signature:

Patient Signature: _____ Date: _____

Name of person completing the form if other than patient: _____

Relationship to patient: _____

 **OKLAHOMA**
P R O T O N • C E N T E R
Assignment of Benefits

First Name: _____ MI: _____ Last Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

May we leave a message? Home Phone Mobile Phone

Email address: _____

DOB: _____ Age: _____ Sex: Male Female

SSN#: _____ Marital Status: Single Married Divorced Widowed

Race: White/Caucasian Black/African American Native Hawaiian/Pacific Islander Asian
Native American/Alaskan Other _____

Ethnicity: Hispanic or Latino YES NO Decline to answer

Employer

Employer Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Responsible Party

Self

Responsible Party: _____ Relationship: _____

Phone: _____

Emergency Contact

#1 Emergency Contact: _____ Relationship: _____

Phone: _____

#2 Emergency Contact: _____ Relationship: _____

Phone: _____

Insurance: See cards provided

Primary Insurance: _____

Secondary Insurance: _____

electronically submitting it to The Oklahoma Proton Center. I understand that my signing and submitting this document in this fashion is the legal equivalent of having placed my handwritten signature on this document.

I understand and agree that by signing and submitting this document I am affirming to the truth of the information contained therein.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Assignment of Benefits

1. I authorize my insurance carrier to release information regarding my coverage to The Oklahoma Proton Center. I also authorize agents of any hospital, treatment center or previous physicians to furnish The Oklahoma Proton Center copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits and quality assurance reviews within The Oklahoma Proton Center.
2. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing services including major medical benefits are hereby assigned to The Oklahoma Proton Center. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to The Oklahoma Proton Center.
3. As a courtesy to you, The Oklahoma Proton Center will verify your health insurance benefits; however, you, the policy holder, is ultimately responsible for knowing your insurance policy coverage, co-pay, deductible and co-insurance and maximum out of pocket. Proton Beam Therapy is provided in an office setting, not a facility, and you may be responsible for a co-pay for an office visit and a physician visit.
4. I understand that I may be responsible for charges not covered or reimbursed by the above agents. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify the The Oklahoma Proton Center of any changes in health care insurance coverage.
5. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with The Oklahoma Proton Center.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I agree, and it is my intent, to sign this document by



Summary of Notice of Privacy Practices

This is a summary of the Notice of Privacy Practices and does not replace the actual Notice of Privacy Practices.

Summary

We keep a record of the healthcare services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at "Your Individual Rights about Patient Health Information" section of the Notice.

Your rights:

1. You may request the following:
 - a. restricted use of your health information (note: we may not be able to grant your request)
 - b. that we not disclose to your health plan those items or services that you self-pay in full
 - c. that we contact you in an alternate way
 - d. an amendment (change or addition) to your record
 - e. a list of disclosures of your health information
2. You may view and receive copies of your health record.
3. You may make complaints related to the privacy of your health information.
4. You may tell us not to share information with your family members.

We may use and disclose your health information in the following circumstances:

- to perform treatment, obtain payment, or carry out operational activities
- to teach and train staff and students
- to conduct research (an Institutional Review Board must approve research projects)
- when required or allowed by law or when you give us written permission

There are extra legal protections for health information about:

- Sexually transmitted diseases
- Drug and alcohol abuse treatment
- Mental health
- HIV/AIDS
- Reproductive health for minors

For more detail, please read the Notice of Privacy Practices for **The Oklahoma Proton Center**.

Acknowledgement of Receipt of Privacy Practices Notice and Patient Bill of Rights & Responsibilities

I acknowledge that I have reviewed and understand this document titled Notice of Privacy Practices.

Patient Name: _____ Date: _____

Personal Representative: _____ Date: _____

The following people may have access to my medical records and information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Effective Date: January 24, 2019

THE OKLAHOMA PROTON CENTER

Patient Bill of Rights & Responsibilities

Patient Bill of Rights

As a patient at The Oklahoma Proton Center ("Center") you have the right to:

- Understand and use these rights. If for any reason you need help with this the Center will provide assistance.
- Give informed consent for treatment and procedures.
- Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or sexual orientation.
- Receive considerate and respectful care in a clean and safe environment.
- Be informed of the name and position of any health care providers who will be caring for you during your treatment at the Center.
- Know the name, position, and function of Center staff involved in your care, and refuse treatment, examination, or observation by that person.
- Receive care in a tobacco-free environment.
- Privacy and confidentiality of all information and records regarding your care.
- Participate in all decisions about your treatment and have the option to have your family participate in these decisions.
- Refuse treatment, examination or observation and be told what effect this may have on your health.
- Have a chaperone present during examination of sensitive areas of your body.
- Obtain a copy of your medical record within a reasonable period of time.
- Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- Receive all the information you need to give Informed consent for any proposed procedure or treatment. This Information shall include the possible risks and benefits of the procedure or treatment.
- Complain without fear of reprisals about the care and services you are receiving and to have the Center respond to you and, if you request it, provide you with a written response. To lodge a complaint, please call The Oklahoma Proton Center Compliance & Ethics Alertline: 855-734-6406

Patient's Responsibilities

The Center Staff strives to provide you, the patient, with the best health care possible. Below are some things you can do to help us achieve that goal:

- Arrive on time for scheduled appointments. If you will not be able to make a scheduled appointment, please call and cancel it so that another patient may be scheduled in your place.
- Give your Care Team all the information she or he will need to determine the best treatment for you; fill out any forms completely and accurately; tell your provider about past and current diagnoses and treatments, such as past illnesses, hospitalizations, and medications; and be as clear as you can about current symptoms, including pain and/or psychological stress.
- Provide correct and complete contact information.
- Be open and honest with your Care Team. If you do not understand or cannot comply with instructions you are given.
- Call your Care Team promptly if your condition worsens or does not follow the expected course.
- Treat fellow patients and Center staff and physicians with the same courtesy and respect that you expect from them. Please respect others' right to privacy as you would ask that your own be respected.
- Make use of information available through the materials in our waiting rooms and on our website. You can make your experience at the Center more satisfying by understanding the way appointments are scheduled and the resources available for after-hours care or emergencies.
- Know the coverage provided by your medical insurance policy, and know what payments you are responsible for regarding applicable co-pays, co-insurance, or deductibles.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____

DATE: _____

Over the last 2 weeks, how often have you been ^{DOB:} bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

+

+

(Healthcare professional: For interpretation of TOTAL, TOTAL: please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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