OKLAHOMA PROTON • CENTER

Self-Reported History Form

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)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots- Location:_____
- ☐ Bronchitis
- ☐ Cancer (previous)
- ☐ Carpal tunnel
- ☐ Claustrophobia
- ☐ Collagen vascular disease
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fractures- Location:_____
- ☐ Gastric ulcers
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol/triglycerides
- ☐ Kidney disease/Dialysis
- ☐ Kidney stone
- ☐ Low blood pressure
- ☐ Metal implants- Location:_____
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Peripheral vascular disease
- ☐ Scleroderma
- ☐ Sexually transmitted diseases
- ☐ Seizures/Epilepsy
- ☐ Skin cancer- Location:_____
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid dysfunction
- ☐ Tuberculosis

Radiation Safety Questions - These questions can affect your ability to have treatment – read carefully.

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

Do you have a pacemaker, defibrillator, or other implanted device? (circle) ☐ Yes ☐ No

Do you have an autoimmune disease like lupus or rheumatoid arthritis? ☐ 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 and when? _____

Please add the type, if know: _____

Do you have any other health issues not previously listed? ☐ Yes ☐ No

_____

For MEN only

Are you experiencing erectile dysfunction?	☐ Yes	☐ No	
Taking medication for erectile dysfunction?	☐ Yes	☐ No	
Pain, swelling or lumps in testes?	☐ Yes	☐ No	
Have you had a colonoscopy?	☐ Yes	☐ No	Date of most recent: _____

For WOMEN only

Age of first menstrual period:	_____		
Date of last menstrual period:	_____		
Number of pregnancies:	_____		
Number of live births:	_____		
Have you ever breastfed?	☐ Yes	☐ No	If yes, months total: _____
Have you achieved menopause?	☐ Yes	☐ No	
Ever used hormone replacement?	☐ Yes	☐ No	If yes, how long: _____
Ever used birth control?	☐ Yes	☐ No	If yes, how long: _____
Any abnormal bleeding or vaginal discharge?	☐ Yes	☐ No	
Have you had a hysterectomy?	☐ Yes	☐ No	
Have you had a mammogram?	☐ Yes	☐ No	
Do you have breast Implants?	☐ Yes	☐ No	
Have you had a recent pelvic exam?	☐ Yes	☐ No	
Have you had a colonoscopy?	☐ Yes	☐ No	Date of most recent: _____

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

Medication Name	**Dose**	**Frequency**

Medications (Continued)

_____

_____

_____

_____

_____

Allergies: List all medication and any other allergies and symptoms 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 quit, when? _____ Packs per day? _____

Smokeless tobacco? ☐ Yes ☐ No Number of years? _____ If you quit, when? _____

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, which material/substance 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

Have you had a Pneumonia vaccine this year? ☐ 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

Are you in a relationship with someone who hurts or harms you? ☐ Yes ☐ No

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

Constitutional/ General
- ☐ Fever
- ☐ Chills
- ☐ Swollen lymph nodes
- ☐ Night sweats
- ☐ Fatigue
- ☐ Sleep issues
- ☐ Weight loss
- ☐ Weight 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 or smell

Lung / Respiratory
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Home oxygen use

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
- ☐ Nighttime urination
- ☐ Incontinence

Endocrine
- ☐ Hot flashes
- ☐ Excessive thirst or hunger
- ☐ Heat or cold intolerance
- ☐ Excessive urination

Musculoskeletal
- ☐ Joint stiffness
- ☐ Paralysis
- ☐ Problems walking
- ☐ Muscle weakness
- ☐ Swelling of ankles/feet
- ☐ Tingling or Numbness

Psychological/ Behavioral
- ☐ Personality changes or excessive anger
- ☐ Depressed feelings
- ☐ Nervousness
- ☐ Suicidal thoughts
- ☐ Hallucinations
- ☐ Memory problems

Neurologic:
- ☐ Headaches
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Double vision
- ☐ Vision changes or loss
- ☐ Dizzy Spells
- ☐ Tremors
- ☐ Blackouts/fainting

Hematologic / Lymphatic:
- ☐ Skin color changes
- ☐ Low blood count
- ☐ Bleeding problems
- ☐ Bruising easily

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 none and 10 being intense, how do you rate your pain? _____

Signature:

Patient Signature: _____ Date: _____

Name of person completing the form if other than patient:

_____

Relationship to patient: _____

OKLAHOMA PROTON • CENTER

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: _____

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 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

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: _____

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 1f 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.

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

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ TODAY'S DATE: _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question.**

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		**VERY LOW**	**LOW**	**MODERATE**	**HIGH**	**VERY HIGH**
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	**NO SEXUAL ACTIVITY**	**ALMOST NEVER OR NEVER**	**A FEW TIMES** (MUCH LESS THAN HALF THE TIME)	**SOMETIMES** (ABOUT HALF THE TIME)	**MOST TIMES** (MUCH MORE THAN HALF THE TIME)	**ALMOST ALWAYS OR ALWAYS**
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you penetrated (entered) your partner?	**DID NOT ATTEMPT INTERCOURSE**	**ALMOST NEVER OR NEVER**	**A FEW TIMES** (MUCH LESS THAN HALF THE TIME)	**SOMETIMES** (ABOUT HALF THE TIME)	**MOST TIMES** (MUCH MORE THAN HALF THE TIME)	**ALMOST ALWAYS OR ALWAYS**
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**DID NOT ATTEMPT INTERCOURSE**	**EXTREMELY DIFFICULT**	**VERY DIFFICULT**	**DIFFICULT**	**SLIGHTLY DIFFICULT**	**NOT DIFFICULT**
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	**DID NOT ATTEMPT INTERCOURSE**	**ALMOST NEVER OR NEVER**	**A FEW TIMES** (MUCH LESS THAN HALF THE TIME)	**SOMETIMES** (ABOUT HALF THE TIME)	**MOST TIMES** (MUCH MORE THAN HALF THE TIME)	**ALMOST ALWAYS OR ALWAYS**
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5 **TOTAL: _____**

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

AUA Symptom Score (AUASS)

PATIENT NAME: _____ TODAY'S DATE _____

(Circle One Number on Each Line)	Not at all	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the apace to the right. **TOTAL: _____**

SYMPTOM SCORE 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been 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 figety 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, please refer to accompanying scoring card). TOTAL:

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

A2662B 10-04-2005