

Follow Up Form



NAME: _____		Preferred Contact Number (Please Check): <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Date of Birth: _____	Email: _____	HOME: _____	CELL: _____
Address: <input type="checkbox"/> No Change		City/State/Zip: _____	
INSURANCE INFORMATION:			
Primary: _____		Member ID: _____	Group: _____
Subscriber Name: _____			
Secondary: _____		Member ID: _____	Group: _____
Subscriber Name: _____			
Spouse Name: _____		Spouse DOB: _____	
Spouse Employer: _____		Phone: _____	
CURRENT MEDS: <input type="checkbox"/> NO CHANGE			
PREFERRED PHARMACY: NAME: _____		LOCATION: _____	PHONE: _____
ALLERGIES: <input type="checkbox"/> NO CHANGE			
PRIMARY CARE PHYSICIAN: _____		REFERRING PHYSICIAN: _____	
LIST OF ANY OTHER PHYSICIANS PRESENTLY SEEING OR HAVE SEEN SINCE LAST VISIT: _____			
Do you have an Implanted Pacemaker or Defibrillator? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please show the Nurse your card.)			
Do you have an Implanted Device? <input type="checkbox"/> Yes <input type="checkbox"/> No Functional? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____			
RECENT SURGERIES OR HOSPITALIZATIONS SINCE LAST VISIT: _____			
HAVE YOU HAD ANY RECENT SCANS OR PROCEDURES DONE SINCE LAST VISIT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
IF YES, LIST TYPE OF SCAN/PROCEDURE, DATE, AND FACILITY _____			
HAVE YOU EVER HAD A COLONOSCOPY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DATE OF PROCEDURE? _____			
DO YOU CURRENTLY SMOKE <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, HOW MUCH PER DAY? _____			
IF MALE, LIST DATE OF LAST PSA: _____			
IF FEMALE, LIST DATE OF LAST MAMMOGRAM: _____		LAST PAP SMEAR: _____	
DO YOU HAVE A LIVING WILL? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a DNR? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a Durable Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes to any of the above, please provide a copy.			
REVIEW OF SYSTEMS (symptoms within last two weeks) (circle all that apply)			
Poor Appetite	Hair Loss	Bloody Vomit	Muscle Weakness
Fatigue	Increased Skin Sensitivity to Sun	Rectal Bleeding	Range of Motion
Fever	Hives/Itching/Rash	Hemorrhoids	Describe _____
Night Sweats	Breast Masses	Black Tarry Stools	Disorientation/Confusion
Weight Change	Nipple Discharge	Nausea	Dizziness
Blurred vision	Nipple Inversion	Abdominal Pain/Cramping	Difficulty Walking
Double Vision	Breast Pain	Vomiting	Headaches
Visual Difficulties	Heart Racing	Burning in Urination	Nerve Pain/Neuropathy
Difficulty Swallowing	Chest Pain	Frequent Urination	Seizure
Impaired Hearing	Swelling to feet and legs	Blood in Urine	Anxiety
Hoarseness	Cough	Impaired Sex Function/Impotent	Hallucinations
Mouth Dryness	Shortness of Breath	Loss of Bladder/Bowel	Depression
Oral Bleeding	Coughing up Blood	Waking at Night to Urinate	Diabetes
Mouth Sores	Chest Pain upon Breathing	Urine Urgency	Hot Flashes
Neck Pain	Wheezing	Vaginal Discharge/Bleeding	Thyroid Disease
Swelling in Neck	Constipation	Bone Pain	Easy Bruising
Blisters on Skin	Diarrhea	Joint Pain	Swollen Lymph Nodes
Other: _____			

I attest that all of the information in this document is true, correct to the best of my knowledge, and understand that my physician will base his opinions and judgements on the same.

Patient Signature _____

Date _____



Patient Name:

Date of Birth:

I hereby authorize **Central Alabama Radiation Oncology** to use, disclose and/or obtain my health information for continuation of medical care.

By providing this Authorization, I understand as follows:

- (1) I understand that I will receive a copy of the authorization form after I sign it.
- (2) I understand that the health information may be subject to re-disclosure by the recipient of the health information. In the case of re-disclosure, such health information may no longer be protected by HIPAA privacy rules.
- (3) I understand that if I refuse to sign this authorization my treatment and/ or payment obligations do not change. While signing this authorization is voluntary, refusal to do so may slow the disclosure of records with any appropriate health or payment institution that requires a signed authorization through internal requirements.
- (4) I understand that revocation of this authorization may be done by me at any time in writing by notifying the Compliance Officer at Central Alabama Radiation Oncology, LLC, 4143 Carmichael Road, Montgomery, AL, 36106. Should I do so, I understand this will not have any effect on uses or disclosures prior to the receipt of the revocation.

Medical Records use only:

Specific description of the health information to be used/disclosed/obtained:

Patient Signature

Date