

**Virginia Cancer Institute  
Patient Demographic Profile**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Patient ID # \_\_\_\_\_ Sex:  M  F  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Cell Primary Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Cell Race  White/Caucasian  African American  American Indian  
 Hispanic  Asian  Other  
Email Address: \_\_\_\_\_ Marital Status:  Married  Single  Divorced  
Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Gender Identity  Identifies as Male  Identifies as Female  Male to Female  
 Female to Male  Genderqueer neither exclusively male nor femal  
 Choose not to disclose  
Living Will  Yes  No On file with VCI?  Yes  No Sexual Orientation  Lesbian, gay or homosexual  Straight or Heterosexual  
DNR  Yes  No On file with VCI?  Yes  No  Bisexual  Don't know  Choose not to disclose  
Durable Medical Power of Attorney  Yes  No  
On file with VCI?  Yes  No

**RESPONSIBLE PARTY**

Same as Patient  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_

**EMPLOYMENT**

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**PRIMARY INSURANCE**

Same as Patient  Same as Guarantor  Other  
Insured Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Policy Group: \_\_\_\_\_

I authorize Virginia Cancer Institute to provide medical treatment to me. I understand that I am financially responsible for charges incurred by me and that in the event my account is turned over to an attorney for collection, I shall be responsible for attorney fees and court costs. I further authorize Virginia Cancer Institute to release medical information necessary to process my claims. In the event any employee is exposed to my blood and/or body fluids, I consent to laboratory testing for Hepatitis B, Hepatitis C and HIV antibodies and that the results of those tests be shared with the exposed party. A photocopy of this information shall be considered as valid as the original.

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**VIRGINIA CANCER INSTITUTE**  
**Consent To Release of Confidential Health Information**

We frequently receive phone calls from family members inquiring about the health status or treatment of a patient. To protect confidentiality, we ask that you notify us of any family members or others to whom you may wish to have your medical information disclosed. If a family member is not listed below, they will NOT be given information regarding your medical care and treatment.

PATIENT NAME: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

RELEASE INFORMATION TO:

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

By signing this consent, I am giving permission to Virginia Cancer Institute, Inc. (VCI) to release my confidential medical information to the individual(s) named above. I understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to VCI. A copy of this consent shall be included with my original records. I further acknowledge that a separate consent or authorization will be required for the production of copies of medical records.

I authorize VCI to disclose all information regarding my medical treatment to the individuals named above unless such release is otherwise limited as follows:

\_\_\_\_\_  
VCI [is \_\_\_/is not \_\_\_] authorized to leave a voicemail using the phone number designated as primary on my account regarding appointment reminders and requests to contact VCI's office.

This consent shall not expire unless I notify VCI. that this release is revoked.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Virginia Cancer Institute

## PATIENT RESPONSIBILITY FOR PAYMENT

You are responsible for any services rendered by the physicians or staff of Virginia Cancer Institute, Inc. (VCI). VCI will bill your health insurance if it is supplied to VCI before or at the time of your service. However, VCI is not responsible for ensuring that its services are covered under your specific insurance policy. You are responsible for being aware of any deductibles, copayments, and non-covered services. You will be expected to pay these amounts at the time of service, unless other arrangements have been made in advance. Some insurance companies require a referral or pre-authorization before you can be treated by a specialist. It is your responsibility to bring this information with you at the time of your visit. We reserve the right not to see you if the referral is not here at the time of your visit.

**YOU ARE RESPONSIBLE FOR ANY SERVICES RENDERED BY VCI THAT ARE NOT PAID BY YOUR INSURANCE CARRIER AND ARE NOT OTHERWISE PRECLUDED BY LAW. YOU ARE RESPONSIBLE FOR ANY COLLECTION AGENCY COSTS, COURT COSTS, OR ATTORNEY'S FEES INCURRED BY VCI IN COLLECTING ANY OUTSTANDING BALANCE FOR SERVICES RENDERED TO YOU.**

### AUTHORIZATION STATEMENTS:

1. **Medicare Patients Lifetime Agreement:** I authorize any holder of medical or other information about me to release such information necessary for the processing of Medicare claims to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries, carriers, billing agents or successors. I further permit a copy of this authorization to be used in place of the original and I request payment under Medicare to be made to VCI for the services and/or supplies furnished during my treatment.
2. I authorize VCI to release or obtain any information necessary in the course of my treatment for billing or clinical requirements.
3. I authorize my health insurance carrier(s) to pay VCI directly for all medical, laboratory, surgical, and other services and procedures rendered to me under the benefits provided by, and within the terms of, my policy.

I understand that I am directly responsible for all services rendered.

I have read and understand all of the above and agree with the terms of this document.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Virginia Cancer Institute

## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: \_\_\_\_\_  
\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail. Unable to communicate with the patient for the following reason:

\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Prepared By: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# VIRGINIA CANCER INSTITUTE

## NOTICE OF PRIVACY PRACTICES

**This Notice of Privacy Practices (“Notice”) explains how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.**

If you have questions about this Notice, please contact our Privacy Officer at 804-673-0134.

We are dedicated to protecting the privacy of your Protected Health Information (PHI). This Notice outlines how your PHI may be used within our practice or network, and how it may be disclosed (shared outside our practice or network) for treatment, payment, or healthcare operations. We may also share your information for other purposes permitted or required by law. Additionally, this Notice describes your rights to access and manage your PHI.

We are legally required to maintain the confidentiality of your PHI and will comply with the terms described in this Notice.

We reserve the right to update this Notice at any time. Any changes will apply to all PHI we maintain. Upon request, we will provide you with the revised Notice by posting it in our office, making copies available upon request or by mail, and posting the updated version on our website (<https://www.vacancer.com/>).

### **Uses and Disclosures of Protected Health Information (PHI)**

We may use or disclose your PHI for your health care treatment. Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office involved in your care to provide health care services.

**Example:** If you are referred to another physician for evaluation, your PHI may be provided to ensure the physician has necessary information for diagnosis or treatment. Similarly, we may share your PHI with specialists or laboratories involved in your care.

Your PHI may be used or disclosed for payment purposes, including billing or collecting payments. PHI may be shared with billing companies, insurance companies, health plans, government agencies, and collection agencies.

**Example:** If you undergo a procedure at our facility, we must share service details (such as x-rays) with your insurance provider for billing. Occasionally, prior authorization is needed before performing certain procedures, requiring us to share your PHI.

We may use or disclose your PHI as needed to support the business activities of our practice, known as healthcare operations.

#### **Examples:**

- Training healthcare personnel, students, or ancillary staff such as billing personnel.
- Performing quality improvement initiatives.
- Resolving internal issues or complaints.

We may use or disclose your PHI in connection with contracted services provided by entities known as “business associates.” Only the minimum necessary PHI will be shared, and these associates are required to safeguard your information.

### **Uses and Disclosures Without Your Authorization**

We may use or disclose your PHI without your permission in the following situations:

- **Required by Law:** Adhering to requirements to report gunshot wounds, suspected abuse, or neglect.
- **Public Health Activities:** Controlling disease, injury, or disability, as required by public health authorities.
- **Health Oversight Activities:** Compliance audits, investigations, and inspections by authorized agencies.
- **Legal Proceedings:** Assisting in legal matters as required by judicial order or lawful process.
- **Law Enforcement:** As authorized by law.
- **Coroners, Medical Examiners, and Funeral Directors:** For identification or determination of cause of death.
- **Research:** With appropriate Institutional Review Board approval.
- **Government Functions:** For national security, military, or correctional institution requirements.
- **Workers’ Compensation:** In accordance with applicable laws.

### **Uses and Disclosures That May Involve Your Input**

Unless you object, we may share your PHI with family members, friends, or persons identified by you, to the extent they are involved in your care or payment. When you are unable to agree or object, the healthcare provider will use professional judgment to determine whether sharing the information is in your best interest. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

We may use or disclose your PHI to notify or assist in notifying a family member or other responsible person, about your location, condition, or death. Further we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

### **Uses and Disclosures Requiring Written Authorization**

The following uses and disclosures require your explicit written consent:

- Marketing communications
- Sale of your information
- Release of psychotherapy notes

Written authorization specifies how you wish your information to be used or disclosed. You may revoke your authorization at any time in writing, except where information has already been acted upon based on prior authorization.

### **Your Privacy Rights**

You have specific rights concerning your PHI. All requests to exercise these rights must be made in writing.

**Right to Access:** You may inspect and obtain copies of your PHI maintained in our records. Electronic copies are available upon request. Certain exceptions may apply, and reasonable fees may be charged. There are some exceptions to records which may be copied, and the request may be denied. You may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**Right to Request Restrictions:** You may ask us not to use or disclose any part of your PHI for treatment, payment, or healthcare operations. While we are not obligated to agree, we will honor agreed-upon restrictions unless the information is needed for emergency treatment. We must accept restriction requests limiting disclosure to a health plan when you pay out of pocket in full.

**Right to Confidential Communications:** You may request communication through alternative means or locations. We will accommodate reasonable requests and will not require explanations.

**Right to Amend:** If you believe your PHI is incorrect or incomplete, you may request an amendment, providing a reason. If denied, you will be given the opportunity to submit a disagreement.

**Right to an Accounting of Disclosures:** You may obtain a list of disclosures of your PHI for purposes other than treatment, billing and payment, or healthcare operations made after April 14, 2003, up to six years back. Additional requests within a 12-month period may incur fees.

**Breach Notification:** In the event of a breach of privacy or security of your health information, we will provide you with written notification of the incident and provide you with applicable steps to reduce the impact of the breach.

**Copy of Notice:** You have the right to obtain a paper copy of this Notice. If you would like a paper copy of this Notice, please request one from our Privacy Officer or request one when you are in our offices.

**Complaints:** If you believe your rights have been violated or have concerns about our privacy practices, contact our Privacy Officer at 804-673-0134. You may also file a complaint with the United States Secretary of Health and Human Services. We will not retaliate against anyone filing a complaint.

### **Additional Notices**

**Substance Use Disorder (SUD) Treatment Privacy:** If we receive or maintain treatment records about you from a SUD program, subject to 42 CFR part 2, or testimony about records, we will not use or disclose it in any civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or we receive a court order, after notice and an opportunity to be heard is provided to you or the record holder. Additionally, any court order for use or disclosure must come with a subpoena or identify applicable legal authority.

**Redisclosure:** PHI disclosed for any reason may be redisclosed by the recipient and is no longer protected by HIPAA or state law.

This Notice was published and is effective as of March 1, 2026.



# Virginia Cancer Institute

## Pre-Screening Patient Assistance Application

This form is optional. Complete only if you wish to pursue Patient Assistance.

Cancer treatments are expensive and, unfortunately, not all insurance companies will pay all of the associated costs. However, there are patient assistance programs available that may help offset some of the expenses you may incur. If you would like for our Financial Counselor to see if you qualify for any of these programs, please complete and provide the following information.

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Household Income: \_\_\_\_\_ Number of People in Household: \_\_\_\_\_

Some programs require proof of income. If approved, you may be asked to provide one or more of the following:

- Copy of your most recent federal tax return, if you file taxes or tax exempt form
- Copies of all current income documentation (W2, SS1, or last three pay stubs)

Attestation: Due to my financial situation, I certify that I may be unable to meet my financial obligation to Virginia Cancer Institute. In addition, I acknowledge that the information I have provided on this form is accurate and complete. I hereby authorize Virginia Cancer Institute to verify any and all information disclosed and understand that this information will be used by Virginia Cancer Institute solely to determine my ability to pay for services provided by the Virginia Cancer Institute. I understand that the Virginia Cancer Institute reserves the right at any time, and without notice, to modify this application form; modify or discontinue any or all of the program and related eligibility criteria; or terminate assistance provided by the program at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

<i>Westend</i>	<i>Johnston Willis</i>	<i>Hanover</i>	<i>Harbourside</i>	<i>Business Office</i>	<i>Southside Regional</i>	<i>Puddledock</i>
8007 Discovery Dr. Suite A Richmond, VA 23229 804-287-3000 FAX 804-673-2731	1401 Johnston Willis Dr. Suite 100 Richmond, VA 23235 804-330-7990 FAX 804-330-2701	7492 Right Flank Rd. Mechanicsville, VA 23116 804-559-2489 FAX 804-730-5847	6130 Harbourside Centre Loop Suite 101 Midlothian, VA 23112 804-378-0394 FAX 804-739-7649	7202 Glen Forest Dr. Suite 200 Henrico, VA 23226 804-673-0134 FAX 804-673-1796	263 Medical Park Blvd. Petersburg, VA 23805 804-431-1100 FAX 804-862-1094	4730 Puddledock Rd. Suite 100 Prince George, VA 23875 804-452-3850 FAX 804-733-3879



# Virginia Cancer Institute

## No Show/Cancellation Policy and Fee

Your care team at Virginia Cancer Institute strives to provide comprehensive, compassionate, and timely care to every patient. To enable a timely clinic flow for all patients, we ask that you notify us at least 24 hours in advance if you need to reschedule or cancel your clinic appointment. **If you are unable to provide a 24-hour cancellation notice, you may be charged a \$50 No Show fee.**

We understand that there are times when you may encounter an emergency and miss a scheduled appointment. We do ask that - as much as possible - VCI is notified of any potential conflicts or changes in your schedule. It is important to us that we balance our clinical teams to support all the patients within the office.

At Virginia Cancer Institute, we do have a patient appointment No-Show/Cancellation policy. Key guidelines of this policy include:

- Patients are expected to provide 24-hour notice of any appointment that needs to be rescheduled or cancelled.
- Patients who arrive more than 15 minutes after his or her scheduled appointment may be rescheduled to another day.
- Patients can be dismissed from Virginia Cancer Institute for regularly -
  - Arriving late to a scheduled appointment.
  - Failing to show up for a scheduled appointment.
  - Providing less than 24 hours of notice to reschedule or cancel an appointment.

We are committed to supporting all our patients with their care needs. And we appreciate your support in recognizing our patient appointment No-Show/Cancellation policy.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Virginia Cancer  
Institute



VIRGINIA  
**SURGICAL**  
INSTITUTE

### Consent for Care Management Services and Programs

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I hereby provide my consent to receive care management services from the employees, agents and staff of Virginia Cancer Institute. Which may include participation in one or more of the following programs. These programs are offered under the direction and supervision of my physician and are designed to provide necessary care through services that address a broad spectrum of patient care needs

**Nutrition Services:**

Personalized nutrition counseling and support to help manage health conditions and improve overall well-being.

**Social Work Services:**

Assistance with emotional, social, and practical needs, including counseling services, access to community resources, and support for patients and families.

**Financial Assistance:**

Guidance and support to help patients understand and manage healthcare costs, insurance benefits, and available financial aid.

**Nursing Care Coordination:**

Comprehensive coordination of care by nursing professionals to ensure seamless communication among providers, symptom management, and ongoing support for patient needs.

**Principal Illness Navigation (PIN):**

PIN provides dedicated support for patients with complex or serious illnesses, helping them navigate the healthcare system, understand treatment options, and access resources tailored to their condition.

**Principal Care Management (PCM):**

PCM offers ongoing management for patients with one high-risk chronic condition. Care managers proactively monitor symptoms, coordinate care, and address barriers to treatment, aiming to improve outcomes and reduce avoidable hospital visits.

**Chronic Care Management (CCM):**

CCM delivers monthly support for patients with two or more chronic conditions. The program includes regular check-ins, medication management, and coordination among healthcare providers to ensure comprehensive care.

**Mental Health Collaborative Care Management (CoCM):**

CoCM integrates behavioral health services into medical care. A care manager works with the patient and a psychiatric consultant to develop and monitor a personalized mental health care plan, with regular reviews and medication recommendations as needed.

**Transitional Care Management (TCM):**

TCM supports patients transitioning from hospital or facility care to home. The program includes an initial contact within two business days of discharge, a face-to-face visit, medication reconciliation, and coordination of all medical conditions for 29 days post-discharge.

**Remote Patient Monitoring (RPM):**

RPM uses technology to monitor patients' health status remotely, allowing care teams to track symptoms, vital signs, and treatment progress between visits. This proactive approach helps identify issues early and supports timely interventions.

**Remote Therapeutic Monitoring (RTM):**

RTM involves remote tracking of therapy adherence and response, using digital tools to collect patient-reported outcomes and support ongoing management of specific conditions. RTM enables care teams to adjust treatment plans based on real-time data.

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**Information Sharing** I understand that my Protected Health Information (PHI) may be shared with supportive software systems and care provider partners as necessary to coordinate and deliver my care. This sharing will comply with all applicable privacy laws and regulations.

**Cost Sharing** I acknowledge that cost sharing, including copays, deductibles, and coinsurance, may apply to both in-person and remote services provided under these programs. I understand that I am responsible for any applicable out-of-pocket costs as determined by my insurance plan and/or financial assistance eligibility.

**Patient Rights** I have the right to ask questions about my care, the services provided, and how my information will be used. I may withdraw my consent at any time by notifying my care team.

**Consent to Care Management Services**

I hereby consent to receive care management services and participate in the programs described above. I understand the nature of these services, the sharing of my Protected Health Information (PHI) as necessary for my care, and my financial responsibilities, including any applicable cost sharing. I acknowledge that I have had the opportunity to ask questions and that my participation is voluntary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Refuse Consent for Care Management Services**

I do not consent to receive care management services or participate in any of the programs described above. I understand that by refusing consent, I will not receive the benefits of these services, and my care will proceed without the additional support outlined in this document.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Withdrawal of Prior Consent**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**VIRGINIA CANCER INSTITUTE**  
**PATIENT HISTORY**

Please fill out this form as completely as you can. It provides vital information to help your physician and staff care for you. All of your medical information is held in strict confidence and is only released to others in accordance with your wishes and federal privacy guidelines.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Date: \_\_\_\_\_ Pharmacy (include address and phone): \_\_\_\_\_

**Please list all physicians involved in your care**

- Physician who referred you to this practice: \_\_\_\_\_
- Primary Care Physician: \_\_\_\_\_
- Surgeon: \_\_\_\_\_
- Radiation Oncologist: \_\_\_\_\_
- Other: \_\_\_\_\_

**Drug Allergies** (name and type of reaction)

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications** (name, dosage, how often, and year started)\*\*attach additional sheet needed\*\*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking blood thinners? \_\_\_\_ Yes \_\_\_\_ No

If yes, how long? \_\_\_\_\_ Who manages your prescription? \_\_\_\_\_

**Current Symptoms**

- [ ] fatigue [ ] fever [ ] chills [ ] night sweats [ ] lethargy [ ] loss of appetite [ ] weight change [ ] ear pain  
 [ ] hearing loss [ ] trouble seeing [ ] sensitivity to light [ ] excessive tears [ ] significant pain [ ] mouth sores  
 [ ] mouth dryness [ ] difficulty swallowing [ ] cough [ ] shortness of breath [ ] swelling [ ] palpitations [ ] rash  
 [ ] dry skin [ ] sensory problems [ ] decreased range of motion [ ] disorientation [ ] breast pain [ ] breast masses  
 [ ] new lumps [ ] hot flashes [ ] nipple discharge [ ] bleeding [ ] nausea [ ] vomiting [ ] heartburn [ ] diarrhea  
 [ ] constipation [ ] incontinence [ ] weakness [ ] difficulty urinating [ ] frequent urinating [ ] constipation [ ] incontinence  
 [ ] weakness [ ] blood in urine [ ] problems with sexual frustration [ ] anxiety [ ] depression [ ] insomnia  
 [ ] dizziness [ ] memory loss [ ] seizures [ ] poor balance

**Medical History** (please check any conditions that apply to you)

	For MD/RN Use Only
<input type="checkbox"/> Allergies/Hay Fever	
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Angioplasty/Stent Placement	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Bleeding Tendency	

<input type="checkbox"/> Cancer Type: Age at diagnosis: Where were you treated?	
<input type="checkbox"/> Chronic Anxiety	
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	
<input type="checkbox"/> Congestive Heart Failure (CHF)	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Emphysema or Chronic Bronchitis	
<input type="checkbox"/> Gastroesophageal Reflux Disease (GERD)	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Hearing Loss	
<input type="checkbox"/> Heart Attack (Myocardial Infarction) (MI)	
<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Irregular Heartbeat	
<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Neuropathy	
<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Peripheral Vascular Disease (PVD) (Arterial Obstruction)	
<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Reflux/Heartburn	
<input type="checkbox"/> Renal Insufficiency (Decreased Kidney Function)	
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Seizure	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Urinary Difficulty	
<input type="checkbox"/> Urinary Incontinence	
<input type="checkbox"/> Venous Thrombosis (Blood Clots)	
<input type="checkbox"/> Visual Loss	
<input type="checkbox"/> Other Medical Problems (please list)	

**Surgical History** (please check any that apply to you)

	Month/Date/Year	For MD/RN Use Only
<input type="checkbox"/> Appendix Removed		
<input type="checkbox"/> Blood Transfusion		
<input type="checkbox"/> Breast Biopsy		
<input type="checkbox"/> Cataract Removal		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> Coronary Artery Bypass		
<input type="checkbox"/> Gall Bladder Removed		
<input type="checkbox"/> Hernia Repair		
<input type="checkbox"/> Hip Replacement		
<input type="checkbox"/> Knee Replacement		
<input type="checkbox"/> Mastectomy		
<input type="checkbox"/> Mastectomy, partial (Lumpectomy)		
<input type="checkbox"/> Other Joint Surgery		
<input type="checkbox"/> Other Surgery		
<input type="checkbox"/> Pacemaker Placement		
<input type="checkbox"/> Prostate Surgery		
<input type="checkbox"/> Tonsils Removed		
<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> Uterus or Ovaries Removed		
<input type="checkbox"/> Vasectomy		

**GYN History** (women only)

# of pregnancies: # of live births:	Menopausal Status: ___ Pre- ___ Post- ___ Peri- ___ Unknown	Age at menopause:
Hormone use: # Years Used ___ Birth Control ___ Type of Birth Control: ___ Post-Menopausal ___ Other	Date of last PAP Smear:  Date of last mammogram:	Other GYN History:

**Family History**

	Alive?	Cancer (specify type)	Age of Death	Age Diagnosed with Cancer	Anemia	Clotting Disorder	Bleeding Disorder
Mother	Y / N						
Father	Y / N						
Sibling	Y / N						
Sibling	Y / N						
Sibling	Y / N						
Other	Y / N						
Other	Y / N						

**Personal History** (please check any that apply to you)

**Marital Status:** Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_

**I live:** \_\_\_ Alone \_\_\_ With a spouse, significant other, family/friend \_\_\_ In assisted living/nursing home

**I have religious objections to blood transfusions:** Yes \_\_\_ No \_\_\_

**I have a living will or advance directive:** Yes \_\_\_ No \_\_\_

If yes, is the living will or advance directive on file with VCI: Yes \_\_\_ No \_\_\_

\_\_\_ **In the event of cardiopulmonary arrest, I do not want to be resuscitated**

\_\_\_ **I have oxygen at home**

**Smoking:** Never \_\_\_ Yes, but quit \_\_\_ Yes, active \_\_\_

If yes: # of years \_\_\_ # packs per day \_\_\_ years quit \_\_\_

**Drinking (Alcohol):** Never \_\_\_ Yes, occasional \_\_\_ Yes, but quit \_\_\_ Yes, active \_\_\_

If yes: # of drinks per week \_\_\_ # drinks per day \_\_\_ years quit \_\_\_

**# of children** \_\_\_

**Current occupation:** \_\_\_\_\_

**Previous occupations:** \_\_\_\_\_

**Military service:** Served in \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_.  
Branch of Service Year Year