Name:______________________________ DOB: ____________
Mailing Address:______________________________________
____

Phone to call with genetic results:______________________
Email to provide to testing lab:_______________________

EO Earle Oki, MD
A Professional Corporation

Cancer Genetic Worksheet

Please answer the following questions about your medical history and your family's history as best as you can.

Demographics

1. Were you adopted? *Yes No*
2. How do you describe yourself? (circle all that apply)
   Caucasian *Black/African American* *American Indian* *Other*________________
   Asian *Native Hawaiian/Pacific* *Islander* *Hispanic/Latina*
3. Are any of your ancestors of Jewish descent? *Yes* *No*

Ob/Gyn History

1. Age when periods started: ______
2. Please circle one: I am still having periods
   I am going through menopause
   My periods have stopped (see #3)
3. Age when your periods stopped:______
   Reason your periods stopped: (circle one)
   - Natural aging (menopause)
   - Uterus removed
   - Uterus and both ovaries removed
   - Uterus and one ovary removed
   - Uterine ablation
   - Ovaries removed
   - Chemotherapy
4. Are you currently pregnant? Yes No
   Due Date _____/_____/_________
5. Did you ever breast-feed? Yes No
   Total months you breastfed ALL of your children: ____
6. Your total number of live-born children: ____
7. Your total number of stillbirths_____
   miscarriages_____
   abortions _____
8. Your age at first live birth: _________
9. Your age at last live birth: __________

Hormonal and Birth Control History

Do you use, or have you ever used, any of the following?

1. Birth control pills, shots or patches *Yes* *No* If yes, total # of years taken:_______
2. Hormone treatments to help you get pregnant *Yes* *No* If yes, how many cycles:_______
3. Hormone replacements *Yes* *No* If yes, total # of years taken:_______
   a. What hormone replacements have you used? *Estrogen only* *Estrogen and progestin* *Other* *Do Not Know*

Mammogram and Surgery History

1. Have you ever had a mammogram? *Yes* *No* Age at first mammogram? ____
   Most recent mammogram? _____/_____ (month/year)
2. Have you ever had a breast biopsy? *Yes* *No* How many breast biopsies have you had? _____
3. Have you ever had a breast removed? *Yes* *No* One or both breasts? *One* *Both*
4. Have you had breast cancer? *Yes* *No* What kind? *Invasive (IDC, ILC)* *In situ (DCIS)* *Don't know*
5. Has a doctor ever told you that you have changes in your breast that may lead to cancer? *Yes* *No* Which type: *LCIS (lobular carcinoma in situ)* *hyperplasia without atypia* *Atypical Ductal Hyperplasia (ADH)* *Atypical Lobular Hyperplasia (ALH)*
   Age breast changes were found: _____
6. Has your uterus been removed? *Yes* *No* Date of surgery: ______/______ (month/year)
7. Have your ovaries been removed? *Yes* *No* Date of surgery: ______/______ (month/year)
   Please circle: *One ovary* OR *Both Ovaries*

Colon History

1. Have you ever had a colonoscopy? *Yes* *No* When was your most recent colonoscopy? _______
2. Have you ever had colon polyps? *Yes* *No* Age when first polyps were found: _____
   How many polyps have you had? _________
3. Has a doctor ever told you that you had colon (bowel) or rectal cancer? *Yes* *No*
4. Have you ever had colon surgery? *Yes* *No*
5. Have you had an upper endoscopy? *Yes* *No* When did you have your last upper endoscopy?_____
6. How often do you take anti-inflammatory medications? ______________________
   (Example: Advil, Aleve, Ibuprofen, Motrin, Naprosyn, Indocin)
7. How often do you take aspirin? ______________________________________
   Do you usually take baby aspirin or regular aspirin? *Baby aspirin (81mg)* *Regular aspirin (325 mg)*

Health History

1. Have you ever had radiation therapy? *Yes* *No*
2. Have you ever had chemotherapy? *Yes* *No*
3. Have you ever had a bone marrow transplant? *Yes* *No*
4. Do you have any other health concerns or diagnoses (diabetes, high blood pressure, etc)?
   ____

Social History

1. About how tall are you? ____ ft. ____ in. About how much do you weigh? _____ lbs.
2. Are you currently working for pay? *Yes / No*
   If Yes: Occupation: ____
3. How often do you drink alcohol?____
4. Have you ever smoked cigarettes? *No* *Yes* *Sometimes*
   If Yes or Sometimes: Do you currently smoke cigarettes? *Yes* *No*
   On average, of the time you smoked, how many cigarettes per day? ____ (~20/pack)
   How many years have/had you smoked? __________ years
   Circle any other form of tobacco you have ever used: *Cigar* *Pipe* *Snuff*

Please continue to next page…

Family Cancer History Information

Have you ever had cancer? Yes No *If yes*, at what age? ______ What type? ____________________

Your Family History Information

FOR AGES, an estimate, such as 50s or 60s, is fine

Please circle age if deceased ex.(63)

How many daughters do (did) you have? ______	Daughter(s) ages: ____________________
How many sons do (did) you have? ______	Son(s) ages: ____________________
How many sisters do (did) you have? ______	Sister(s) ages: ____________________
How many brothers do (did) you have? ______	Brother(s) ages: ____________________
How many sisters does (did) your Mother have? ______	Aunt(s) ages: ____________________
How many brothers does (did) your Mother have? ______	Uncle(s) ages: ____________________
How many sisters does (did) your Father have? ______	Aunt(s) ages: ____________________
How many brothers does (did) your Father have? ______	Uncle(s) ages: ____________________

Is your Mom still living?	*Yes No Don't Know*	Mom's age (now or at death): ______
Is your Dad still living?	*Yes No Don't Know*	Dad's age (now or at death): ______
Is your **mom's** mom still living?	*Yes No Don't Know*	Grandmother's age: ______
Is your **mom's** dad still living?	*Yes No Don't Know*	Grandfather's age: ______
Is your **dad's** mom still living?	*Yes No Don't Know*	Grandmother's age: ______
Is your **dad's** dad still living?	*Yes No Don't Know*	Grandfather's age: ______

Have any of your relatives been diagnosed with cancer? Yes No *If Yes:* Please list below:

Relationship (Grandmother, Aunt, etc.)	Mom's side – M Dad's side – D	Type of Cancer	Age Cancer was Diagnosed
EXAMPLE: Uncle	D	Colon	65

Earle Oki, MD Professional Corporation

Maternal-Fetal Medicine, Prenatal Diagnosis and High Risk Obstetrical

Financial Policy

- All co-pays are due in full at time of service.
- There is a $100.00 no show policy for appointments not cancelled 24hrs in advance or missed appointments. If not paid you will be responsible for all collection fees.
- I understand that it is my responsibility to pay Dr. Oki, MD Professional Corporation for all services received. Non-payment may result in account assigned to collection agency.
- I understand it is my responsibility to know my insurance plan and benefits and understand I will be billed for any services provided that is not covered under my insurance policy.
- I understand there is a return check fee of $35.00. In the event of a return check any self-pay discounts will be removed and I will be responsible for balance in full.
- Self-pay patients will be given a 30% discount for balances paid in full at the time of service **OR** payment arrangements must be made prior to appointment. First payment will be due at the time of service.

I understand and agree that in the event legal action is commenced to enforce my obligations hereunder I will pay all court costs and attorney fees.

______________________________ ________________________

Patient/Guardian Signature Date

Earle Oki, MD Professional Corporation

Maternal-Fetal Medicine, Prenatal Diagnosis and High Risk Obstetrics

These documents contain information that is intended only for the use of the individual or entity to whom it is addressed and may contain protected health information that if privileged, confidential and exempt from disclosure under the Health Insurance Portability and Accountability Act of 1995 (HIPAA). The recipient agrees to use the information only for the purposes for which they have been engaged and agrees to maintain the integrity and confidentiality of the transmitted information in accordance with HIPAA regulations. If you are not the intended recipient of these documents, you are hereby notified that any dissemination, distribution of copying of this communication is strictly prohibited. If you received this communication in error, please notify Earle Oki, MD Professional Corporation immediately at 775-829-0573. Thank you.

ACKNOWLEDGEMENT

I, ______________________ hereby acknowledge that I have received a copy of the Privacy Practices Notice.

Signature: ____________________________________ Date: ___________________

ACKNOWLEDGEMENT REFUSED

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

Date: _______________

Name of Patient: ____

Reason for refusal/failure: ____

Signature of Provider Employee: ____

FILE SIGNED COPY OF THIS PAGE WITH PATIENT'S RECORD

Earle Oki, MD
A Professional Corporation

Patient Name ______ (Last) ______ (First) ______ (Middle) Date of Birth ______ Sex Female

Single Married Separated Divorced Social Security Number ______

Address ______ (Number & Street) ______ (City) Nevada (State) ______ (ZIP) Home Phone ______

Mobile Phone ______

Patient's Employer ______ (Name & Address) Work Phone ______

Parent or Spouse Name ______ Date of Birth ______

Parent or Spouse Employer ______ (Name & Address)

Parent or Spouse Social Security Number ______

Home Phone ______

Work Phone ______

Mobile Phone ______

Person whom we may contact in event of emergency

Name ______ (Last) ______ (First) ______ (Middle)

Address ______ (Number & Street) ______ (City) Nevada (State) ______ (ZIP)

Home Phone ______

Mobile Phone ______

Are you allergic to any medication or latex? Yes No Don't Know

If Yes, enter the medication(s) here ______

I plan to make payment of my medical expenses as follows (check one or more):

Cash Check Other ______

Insurance Information - Self	Insurance Information - Spouse
Subscriber's Name	Subscriber's Name
Name of Insurance Plan	Name of Insurance Plan
Effective Date / Group #	Effective Date / Group #

Do you plan to apply for Medicaid/MediCal? Yes No

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements from Earle Oki, MD Professional Corporation, promptly upon presentment thereof unless credit arrangement are agreed upon in writing prior to treatment. Charges shown by Earle Oki, MD Professional Corporation Statements are agreed to be correct and reasonable unless Earle Oki, MD Professional Corporation is notified in writing within thirty days of the billing date. In the event legal action or collection should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/We agree to pay reasonable attorney's fee, collection costs, or other such costs as court orders.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to Earle Oki, MD Professional Corporation where applicable, but without Earle Oki, MD Professional Corporation assuming responsibility for the collection thereof. I understand I must notify Earle Oki, MD Professional Corporation of any charges of my address and/or telephone number.

Signature ______ Date ______