CPRCC Charlotte Hall Office
30077 Business Center Drive
Charlotte Hall, Maryland 20622

CHESAPEAKE POTOMAC REGIONAL CANCER CENTER
REGISTRATION FORM
(Please Print)

CPRCC Waldorf Office
11340 Pembrooke Sq, Suite 201
Waldorf, Maryland 20603

Today's date:

PATIENT INFORMATION

❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Patient's First Name:	Middle:	Last:

Street address:	City:	State	Zip Code:
Mailing address:	City:	State	Zip Code:

Gender: ❑ M ❑ F	Race (check all that apply) : ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other

Home Phone: ( )	Work Phone: ( )	Mobile Phone: ( )	Home Fax: ( )
Email:	Social Security Number:	Date of Birth:	Preferred Method of Contact: ❑ Phone ❑ US Postal ❑ Email:
Preferred Language:		Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	Marital status (circle one) Single / Mar / Div / Sep / Widow
Employer:	Employer Address:		Employer phone no.: ( )
Occupation:	Advance Directive and/or Medical Power of Attorney: ❑ Yes ❑ No		

IN CASE OF EMERGENCY

Spouse's Name:		Home phone : ( )	Work phone : ( )
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )

PHYSICIAN INFORMATION

Referring Physician:	Contact Number:
Surgeon:	Contact Number:
Medical Oncologist:	Contact Number:
Family/Primary Care Physician:	Contact Number:
Previous Radiation Therapy: ❑ Y ❑ N	Facility Name and Contact Number:

Insurance Subscriber Name:	**Subscriber Date of Birth:** \ \

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chesapeake Potomac Regional Cancer Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Pharmacy Name: ______________________________**Location:** _________________ **Phone:** ____________

•**Are you Diabetic?** **Yes** **No** •**Do you have Renal Failure?** **Yes** **No**

•**Do you have Asthma?** **Yes** **No** •**Are you allergic to Iodine or Seafood?** **Yes** **No**

Allergies: (Medications, foods, environmental, etc.)____

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Current Medications

Medication Name	Dose	Frequency	Reason for Taking

Vitamins, Herbal or Nutritional Supplements

Revised April 13, 2011

PLEASE CHECK OFF ANY OF THE SYMPTOMS BELOW THAT YOU HAVE HAD IN THE PAST 2 MONTHS

BREAST/GENITAL
- ☐ Mass on self exam
- ☐ Discharge

BLOOD/LYMPH
- ☐ Unusual bruising
- ☐ Bleeding gums

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest pain
- ☐ Pacemaker
- ☐ Leg pain with walking
- ☐ Ankle swelling

CONSTITUTIONAL
- ☐ Weight loss

lbs___ over___mos.
- ☐ Weight gain

lbs___ over___mos.
- ☐ Change in appetite
- ☐ Tub Feeding

_______ cans per day

____________ supplement
- ☐ Fevers
- ☐ Sweats
- ☐ Fatigue
- ☐ Dizziness
- ☐ Weakness
- ☐ Use a walker
- ☐ Use a cane
- ☐ Use a wheelchair

DENTAL
- ☐ Dentures
- ☐ Crowns
- ☐ Nose bleeds

Last dental exam/cleaning

____

ENDOCRINE
- ☐ Excessive thirst
- ☐ Known thyroid problem
- ☐ Feel too hot/cold
- ☐ Diabetes

EARS, NOSE AND THROAT
- ☐ Nose bleeds
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Jaw pain

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts

GASTROINTESTINAL
- ☐ Difficulty swallowing
- ☐ Difficulty chewing
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Dark, tarry stools
- ☐ Blood in stools
- ☐ Reflux

GYNECOLOGIC

Age at first pregnancy ____

Pregnancies ____

Live births ____

Age of first menarche ____

Menopause ____

Hormone use Y N

Last Pap Smear ________

Last menstrual period

Last Mammogram ________

Last BSE ___________

Pregnant Y N

Sexually active Y N

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Gout
- ☐ Arthritis

NEUROLOGIC
- ☐ Weakness
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures/convulsions
- ☐ Numbness

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Mood changes

RESPIRATORY
- ☐ Short of breath
- ☐ Short of breath on exertion
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm

SKIN
- ☐ New rash
- ☐ Sensitivity to sun
- ☐ Change in the size or color of a lesion

URINARY SYSTEM
- ☐ Difficulty urinating
- ☐ Difficulty controlling the bladder
- ☐ Getting up at night to urinate
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Kidney Disease/Dialysis