

My dear patient,



I want you to know how much I appreciate your careful attention to completing ALL of these forms.

I know it seems like a lot of paperwork, but each question covers an important aspect of your health and may influence the decision about the best type of treatment for you.

When you help me to fully understand your situation, together, we become a powerful team for your health.

Thank you in advance!

Dr Holmes

|   |  |   |
|---|--|---|
| Any time you make changes to this form please change the date   |  | Date  |
| Last Name   | First Name   | Date of Birth   |
| What is the reason you came here today?<br><input type="checkbox"/> Regular Checkup <input type="checkbox"/> On Chemo <input type="checkbox"/> On Pills <input type="checkbox"/> New Problem  |  | <b>MD NOTES</b>   |
| <b>Performance</b>  |  | Dear Patient:<br>If you need more space, you may write in the MD NOTES column.<br>☺ Thanks! Dr H. |
| How are you feeling since the last visit?<br><input type="radio"/> 100% normal activity and no problems<br><input type="radio"/> 90% normal activity, but have some symptoms<br><input type="radio"/> 80% normal activity, but takes effort<br><input type="radio"/> 70% take care of myself, but can't do normal activity or work<br><input type="radio"/> 60% need SOME help taking care of myself<br><input type="radio"/> 50% need LOTS of help<br><input type="radio"/> 40% use wheelchair<br><input type="radio"/> 30% use cane |  |   |
| <b>Ability to walk</b>  |  |   |
| <input type="radio"/> Walk without help <input type="radio"/> Need cane <input type="radio"/> Walker <input type="radio"/> Wheel chair <input type="radio"/> Other support  |  |   |
| <b>Pain</b>   | <b>Nausea on a scale of 0 ☺ to 10 ☹</b>  |   |
| <input type="radio"/> None <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe   | (0: none; 10: vomiting)  |   |
| <b>Pain level on a scale of 0 ☺ to 10 ☹</b>   | <b>Depression on a scale of 0 ☺ to 10 ☹</b>                                      |   |
| (10: having a baby or a kidney stone)   | (0: none; 10: severe)  |   |
| <b>Weight</b>   |  |   |
| <input type="radio"/> No change in last 1 year <input type="radio"/> Gain <input type="radio"/> Loss How many lbs in last year?   |  |   |
| <b>General</b>  |  |   |
| <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot flashes <input type="checkbox"/> Yes but no change <input type="checkbox"/> No problems   |  |   |
| <b>Have you seen any new doctors?</b>   | <b>Have you been hospitalized or had surgery?</b>                                |   |
| <input type="radio"/> No <input type="radio"/> Yes  | <input type="radio"/> No <input type="radio"/> Yes                               |   |
| <b>If yes, Please list.</b>   | <b>If yes, what for?</b>   |   |
|   |  |   |
| <b>New Problems or Questions?</b>   |  |   |
|   |  |   |
| <b>Vaccinations &amp; Immunizations Since Last Visit?</b>   |  |   |
| <input type="checkbox"/> Flu  | <input type="checkbox"/> Hepatitis   |   |
| <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Shingles  |   |
| <input type="checkbox"/> Tetanus  |  |   |
| <b>Family Situation</b>   |  |   |
| <input type="checkbox"/> New Cancers <input type="checkbox"/> Serious Illnesses <input type="checkbox"/> Yes but no change <input type="checkbox"/> No problems   |  |   |
| <b>Personal Situation</b>   |  |   |
| <input type="checkbox"/> New Habits <input type="checkbox"/> Alcohol <input type="checkbox"/> Smoking <input type="checkbox"/> New Job <input type="checkbox"/> New Address <input type="checkbox"/> People Moving In/Out   |  |   |
| <b>Gland (Endocrine) Problems</b>   |  |   |
| <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Colder or hotter than everyone else                     |   |
| <input type="checkbox"/> Jittery  | <input type="checkbox"/> More thirsty than usual                                 |   |
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems |   |
| <b>Head and Eyes</b>  |  |   |
| <input type="checkbox"/> Headaches <input type="checkbox"/> Vision Change <input type="checkbox"/> Cataracts <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |   |
| <b>Blood</b>  |  |   |
| <input type="checkbox"/> Bleed <input type="checkbox"/> Bruise <input type="checkbox"/> Anemia <input type="checkbox"/> Other <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems  |  |   |

| Ears, Nose, and Throat  |  | MD NOTES   |
|---|--|--|
| <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hearing change <input type="checkbox"/> Ear infection <input type="checkbox"/> Nose bleed<br>Mouth: <input type="checkbox"/> Yeast infection <input type="checkbox"/> Soreness <input type="checkbox"/> Ulcers<br><input type="checkbox"/> Cold sores <input type="checkbox"/> Fever blisters <input type="checkbox"/> Dental surgery <input type="checkbox"/> Toothache<br><input type="checkbox"/> Tongue soreness <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems           |  |  |
| <b>Upper GI</b>   |  |  |
| <input type="checkbox"/> Indigestion <input type="checkbox"/> Reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Can't drink milk<br><input type="checkbox"/> Acid reflux <input type="checkbox"/> Gallbladder <input type="checkbox"/> Other <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |  |
| <b>Lower GI</b>   |  |  |
| <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Watery <input type="checkbox"/> Soft<br><input type="checkbox"/> Blood in stool <input type="checkbox"/> Dark black "tar-like" stool <input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Fissures <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems  |  |  |
| <b>Lungs</b>  |  |  |
| <input type="checkbox"/> Short of breath when relaxing <input type="checkbox"/> Short of breath on exertion<br><input type="checkbox"/> Smoking <input type="checkbox"/> Wheezing <input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Cough   Does anything come up? <input type="radio"/> No <input type="radio"/> Yes<br><input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |  |
| <b>Heart</b>  |  |  |
| Heart rhythm: <input type="checkbox"/> Too fast <input type="checkbox"/> Too slow <input type="checkbox"/> Irregular<br><input type="checkbox"/> Chest pain sitting <input type="checkbox"/> Chest pain on exertion <input type="checkbox"/> Feet or leg swelling<br><input type="checkbox"/> Must sleep sitting up <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems  |  |  |
| <b>Breast</b>   |  |  |
| <input type="checkbox"/> Soreness <input type="checkbox"/> Swelling <input type="checkbox"/> Redness <input type="checkbox"/> Changes<br><input type="checkbox"/> New lump <input type="checkbox"/> Lump in armpit <input type="checkbox"/> New surgery <input type="checkbox"/> Arm swelling<br><input type="checkbox"/> Can't move arm normally <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems  |  |  |
| <b>Bladder</b>  |  |  |
| <input type="checkbox"/> Urine burns <input type="checkbox"/> Urine infection <input type="checkbox"/> Blood in urine <input type="checkbox"/> Color change<br><input type="checkbox"/> Hard to start or stop urine <input type="checkbox"/> Lose control <input type="checkbox"/> No Problems<br><input type="checkbox"/> Have to get up at night <input type="checkbox"/> Have to go frequently <input type="checkbox"/> Yes, but no change   |  |  |
| <b>Vagina</b>   |  |  |
| <input type="checkbox"/> Yeast <input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Dryness <input type="checkbox"/> Odor<br><input type="checkbox"/> Sex causes pain or bleeding <input type="checkbox"/> Taking Tamoxifen<br>Still having periods: <input type="radio"/> No <input type="radio"/> Yes   Last period:<br>Last pelvic exam: <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |  |
| <b>Skin / Hair / Nails</b>  |  |  |
| <input type="checkbox"/> Skin rashes <input type="checkbox"/> Itching <input type="checkbox"/> Moles or sores <input type="checkbox"/> Hair loss<br><input type="checkbox"/> Toenail changes <input type="checkbox"/> Fingernail changes<br><input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems  |  |  |
| <b>Muscles / Joints / Bones</b>   |  |  |
| <input type="checkbox"/> Muscle pain <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Back pain <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |  |
| <b>Nervous System</b>   |  |  |
| <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Fainting <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Confusion<br><input type="checkbox"/> Forgetful <input type="checkbox"/> Speech problems <input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems   |  |  |
| <b>Emotional</b>  |  |  |
| <input type="checkbox"/> Coping well <input type="checkbox"/> Not coping <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed<br><input type="checkbox"/> Not having any fun <input type="checkbox"/> Crying <input type="checkbox"/> Feel guilty <input type="checkbox"/> Problems with sex<br><input type="checkbox"/> Can't sleep <input type="checkbox"/> Sleep too much <input type="checkbox"/> Tired all the time<br><input type="checkbox"/> Eat when stressed <input type="checkbox"/> Eat too much or too little<br><input type="checkbox"/> Yes, but no change <input type="checkbox"/> No problems |  |  |
| <b>Patient Name</b>   |  | <b>Date / Time</b> am or pm (circle one)                     |
| <b>Responsible Party Name</b>   |  | <b>Relationship</b> <b>Date / Time</b> am or pm (circle one) |

## Medication Update

|  |          |              |           |               |   |
|--|----------|--------------|-----------|---------------|---|
| Name   |          | Today's Date |           | Date of Birth |   |
| <b>Medicines Prescribed by Dr. Holmes</b>  |          |              |           |               |   |
| 1.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| 2.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| 3.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| 4.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| 5.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| 6.   | Medicine | Dose         | How Often | What it's for | Need Refill?<br><input type="checkbox"/> Y <input type="checkbox"/> N |
| <b>Medicines Prescribed by Other Doctors</b>   |          |              |           |               |   |
| 1.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| 2.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| 3.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| 4.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| 5.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| 6.   | Doctor   | Medicine     | Dose      | How Often     | What it's for   |
| <b>Vitamins / Minerals / Herbs / Natural Remedies/Over The Counter Drugs</b>                           |          |              |           |               |   |
| 1.   | Medicine | Dose         | How Often | What it's for |   |
| 2.   | Medicine | Dose         | How Often | What it's for |   |
| 3.   | Medicine | Dose         | How Often | What it's for |   |
| 4.   | Medicine | Dose         | How Often | What it's for |   |
| 5.   | Medicine | Dose         | How Often | What it's for |   |
| 6.   | Medicine | Dose         | How Often | What it's for |   |
| <b>Allergies: Medicines, Environment, Food, Things On Your Skin</b>                                    |          |              |           |               |   |
| 1.   | Name     | Reaction     |           |               | Year  |
| 2.   | Name     | Reaction     |           |               | Year  |
| 3.   | Name     | Reaction     |           |               | Year  |
| In lieu of a physical signature my name, the date, and my confidential PIN will certify this document. |          |              |           |               |   |
| Patient or Responsible Party Name  |          | Relationship |           | Date          | PIN   |

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## Assignment of Benefits and Financial Responsibilities

| Patient Information  |   |   |   |  |
|--|---|---|---|--|
| Last Name  | First Name  | Middle  | Age                                     |  |
| Home Phone   | Cell Phone  | Work Phone  |   |  |
| Home Address   | City  | State   | Zip Code                                |  |
| Mailing Address  | City  | State   | Zip Code                                |  |
| Email Address  |   |   |   |  |
| Gender<br><input type="radio"/> Male <input type="radio"/> Female  |   | Marital Status<br><input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Significant Other |   |  |
| Home Health / Hospice Name   |   |   |   |  |
| <i>The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.</i>  |   |   |   |  |
| Race   |   |   |   |  |
| <input type="checkbox"/> Caucasian   | <input type="checkbox"/> African American                                 | <input type="checkbox"/> Hispanic   | <input type="checkbox"/> Chamorran      | <input type="checkbox"/> Asian/Indian/Pakistani/Sri Lankan |
| <input type="checkbox"/> Chinese   | <input type="checkbox"/> Fiji Islander                                    | <input type="checkbox"/> Filipino   | <input type="checkbox"/> Guananian NOS  | <input type="checkbox"/> Kampuchean/Cambodian              |
| <input type="checkbox"/> Hawaiian  | <input type="checkbox"/> Hmong  | <input type="checkbox"/> Japanese   | <input type="checkbox"/> Korean         | <input type="checkbox"/> Melanesian NOS                    |
| <input type="checkbox"/> Laotian   | <input type="checkbox"/> Micronesian NOS                                  | <input type="checkbox"/> New Guinean  | <input type="checkbox"/> Polynesian NOS | <input type="checkbox"/> Pacific Islander NOS              |
| <input type="checkbox"/> Samoan  | <input type="checkbox"/> Native American                                  | <input type="checkbox"/> Tahitian   | <input type="checkbox"/> Thai           | <input type="checkbox"/> Tongan                            |
| <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Other Asian including Asian NOS and Oriental NOS |   |   | <input type="checkbox"/> Other                             |
| Employer   | Address   | City  | State                                   | Zip Code   |
| Responsible Party Name   |   | Relationship  | Telephone                               |  |
| Emergency Contact / Spouse / Next of Kin Name  |   | Relationship  | Telephone                               |  |
| Alternate Emergency Contact Name   |   | Relationship  | Telephone                               |  |
| Referring Physician  |   | Primary Care Physician  |   |  |
| Insurance Information  |   |   |   |  |
| Primary Insurance  | Telephone   | Policy Number   | Group Number                            |  |
| Subscriber Name  | Date of Birth   | Employer  |   |  |
| Secondary Insurance  | Telephone   | Policy Number   | Group Number                            |  |
| Subscriber Name  | Date of Birth   | Employer  |   |  |
| Tertiary Insurance   | Telephone   | Policy Number   | Group Number                            |  |
| Subscriber Name  | Date of Birth   | Employer  |   |  |
| 1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).<br>2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology P.A.<br>3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. 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 Texas Oncology P.A.<br>4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.<br>5. Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check. |   |   |   |  |
| 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. In lieu of a physical signature my name, the date, and my confidential PIN will certify this document.  |   |   |   |  |
| Patient or Responsible Party Name  |   | Relationship  | Date                                    | PIN  |

