CENTRA
Alan B. Pearson
Regional Cancer Center

1701 Thomson Drive
Lynchburg, Virginia 24501

PHONE: 434.200.5925
WEB: CentraHealth.com

Dear Patient,

Welcome to our practice! At Centra Lynchburg Hematology Oncology, our patients are at the center of everything we do. Putting you first with expert care and long-lasting partnerships is our life's work. We thank you for trusting us with your healthcare needs, and we look forward to seeing you.

We know this can be a stressful process and hope this information helps you prepare for your time with us.

We also invite you to visit our new patient welcome page, www.CentraHealth.com/CancerCenterWelcome, where you can find frequently asked questions, digital copies of paperwork, and videos explaining the treatment process.

To prepare for your visit please review the information below:

1) Location – Our office is located in the Alan B. Pearson Regional Cancer Center at 1701 Thomson Drive in Lynchburg, VA, near Lynchburg General Hospital. You can park and enter through the main entrance at the middle of the building. Once you enter the lobby, make your way to the second floor by taking the stairs to your right or the elevators at the back of the lobby.

2) Completed Forms – Please complete the enclosed forms and return them to our office before your visit or bring them with you to your appointment.

3) Important Billing Information – On the day of your appointment you will register with our front desk receptionist to provide your insurance details, contact information and sign any required forms.
Please bring the following:

- ❏ Your Photo ID
- ❏ Medical and Prescription Insurance cards and copayment, if applicable
- ❏ Current medication list or original bottles (including prescriptions, hospital discharge medications and instructions, over-the-counter, supplements and herbal medications). "My Medicine List" is enclosed in this packet for your convenience.
- ❏ Enclosed completed forms.
- ❏ If your visit requires a referral or pre-authorization, please coordinate with your insurance carrier(s) or your primary care provider's office to make sure these tasks are complete.

If you have medical records that should be transferred to us, please contact our office about signing a records release. It is very important that we obtain this information before your appointment.

We are looking forward to participating in your care. If you have any questions prior to your appointment, please give us a call at 434.200.5925 or get more information at CentraHealth.com/CancerCenterWelcome.

Sincerely,

Centra Lynchburg Hematology Oncology
Alan B. Pearson Regional Cancer Center

☐ Centra Lynchburg Hematology Oncology
1701 Thomson Drive, Suite 200
Lynchburg, Virginia 24501
Phone: 434-200-5925 Fax: 434-485-7840

☐ Centra Southside Hematology Oncology
800 Oak Street
Farmville, Virginia 23901
Phone: 434-315-2690 Fax: 434-315-2697

New Patient Worksheet

Please bring this form with you on your first visit

Name:_____

Date of Birth:_____

Phone Number:_____

Address:_____

_____

Email Address:_____

Primary Care Physician:_____

Other Physicians you see:

_____

_____

Illnesses and Injuries with dates:

_____

_____

_____

_____

_____

_____

Past Surgeries with dates:

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

_____

_____

Emergency Contact:_____

Relationship to Patient:_____

Emergency Contact Phone Number:_____

Marital Status:_____

Occupation:_____

Tobacco:

☐ Yes / ☐ No

Packs per day:_____ Years_____

Alcohol:

☐ Yes / ☐ No Types:_____

Amount per day:_____ Years_____

Any illnesses that run in the family_____

_____

_____

_____

Relatives with cancer or blood problems:

Father_____

Grandfather_____

Grandmother_____

Mother_____

Grandfather_____

Grandmother_____

Brothers and sisters_____

Children_____

_____

Patient Label

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Family Cancer History

Please fill out the form below if you or your family members have had a cancer. Be sure to mark the cancer type, list the approximate age when diagnosed and if they passed away from cancer.

	Breast Age	Colon Age	Colon Polyps Age	Melanoma Age	Ovary Age	Pancreas Age	Stomach Age	Uterus Age	Other Age	Deceased Y or N
YOU										
Mother										
Father										
Sons										
Daughters										
Brothers										
Sisters										
Nieces										
Nephews										
Mother's Side										
Grandmother										
Grandfather										
Aunts										
Uncles										
Cousins										
Father's Side										
Grandmother										
Grandfather										
Aunts										
Uncles										
Cousins										

This data will be reviewed by clinical providers to determine if additional information is required or if it is recommended for you and your family members to have genetic testing. Genetic testing is a blood test to determine if you or a family member have an inherited tendency to develop cancer. The office staff will contact you to set up additional appointments if needed.

Name:_____

Date of Birth:_____

Office notes: _____

_____

Patient Label

CENTRA

Name: _____ Date of Birth: _____

My Medicine List

What I'm Using (Name of the medicine – generic and brand name)	**What it Looks Like** (Color, shape, size, markings, etc.)	**How Much** (Dosage, amount, etc.)	**How to Use & When to Use**	**Start/ Stop Dates**	**Why I'm Using** (Notes about my medicine)	**Who Told Me to Use It** (Who Prescribed This Medicine)
Enter ALL prescription (Rx) medicine (including samples), over the counter (OTC) medicines and supplements/vitamins						

Bring this list with you to EVERY visit. Keep it up to date with all new medicines.

Bring to all other doctor visits, and drug store. Write down all new medications or dose changes.

Be sure to carry the list with you at all times in case of an emergency.

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Date: _____

Name: _____

Date of Birth: _____

Depression/Emotional Problems Screening

Over the past two weeks have you experienced:

Little interest or pleasure in doing things	**Yes_____**	**No_____**
Feeling down, depressed, or hopeless	**Yes_____**	**No_____**
Thoughts of harming yourself or others	**Yes_____**	**No_____**

Which statement below describes your energy level? Choose one.

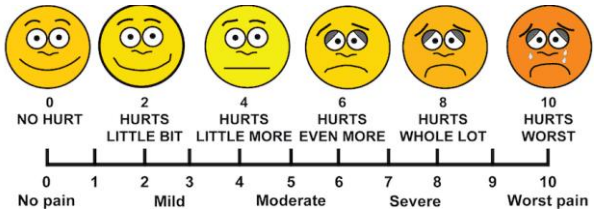
- ☐ **Fully able to carry on all pre-disease activities without restriction**
- ☐ **No physically strenuous activity, but ambulatory and able to carry out light house or office work.**
- ☐ **Ambulatory, capable self-care, unable to perform any work activities (50% or more of the day)**
- ☐ **Capable of limited self-care, confined to a bed or wheelchair (More than 50% of waking hours)**

Please mark current problems below:

☐ **None of the problems mentioned below**

Please rate pain:_____

Location:_____



General
- ☐ Anxiety
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Sleep Apnea
- ☐ Weight loss

Date of Flu Vaccine:
_____

Eyes
- ☐ Blurred/ Double vision

Ear/Nose Mouth/Throat
- ☐ Dentures
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Mouth dryness
- ☐ Mouth sores
- ☐ Nosebleed
- ☐ Ringing ears
- ☐ Swallowing Pain/Trouble
- ☐ Taste altered
- ☐ Tooth problems

Neck
- ☐ Masses
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling

Skin
- ☐ Changing Moles
- ☐ Dry skin
- ☐ Hair loss
- ☐ Itching
- ☐ Rash

Arms
- ☐ Swelling/Fullness

Breasts
- ☐ Breast masses
- ☐ Breast swelling
- ☐ Nipple discharge
- ☐ Nipple inversion

Heart / Circulation
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Irregular heart beat
- ☐ Pacemaker / Defibrillator
- ☐ Palpitations

Respiratory / Lungs
- ☐ Cough
- ☐ Coughing up blood
- ☐ Coughing up mucus
- ☐ Breathing problems
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black or bloody stools
- ☐ Constipation
- ☐ Diarrhea / Loose stool
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

Urine / Genital/ Sexual
- ☐ Blood in urine
- ☐ Urgency or burning
- ☐ Decreased sexual function
- ☐ (MEN) Erection Difficulty
- ☐ Loss of urine control
- ☐ Pain with sex
- ☐ Urinating at night
- ☐ Urinating > every 2hours
- ☐ Change in urine color

Female Only
- ☐ Vaginal discharge or bleeding

Is there a possibility that you could be pregnant?

Yes ☐ No ☐ Initials:_____

Musculoskeletal
- ☐ Bone pain
- ☐ Joint pain or swelling
- ☐ Muscle weakness
- ☐ Stiffness

Neurologic
- ☐ Balance problem
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness of hands or feet
- ☐ Seizure
- ☐ Tingling

Hormone
- ☐ Hot flashes

Blood / Lymphatic
- ☐ Easy bruising
- ☐ Swollen lymph glands

Tobacco Use
- ☐ No
- ☐ Yes / How many daily_____

Alcohol Use
- ☐ No
- ☐ Yes / How many daily_____

Other problems:
_____