Blood & Marrow Transplant Group of Georgia
Patient Demographic Form

*****Please complete entire form---Do not leave any blanks*****

BLOOD MARROW TRANSPLANT GROUP OF GEORGIA
DEMOGRAPHIC FORM

□**H. Kent Holland, MD** □**Lawrence Morris, MD** □**Scott Solomon, MD** □**Asad Bashey**, MD □**Melhem Solh**, MD
(Please check your consulting physician)

PLEASE FILL OUT FRONT AND BACK OF THIS FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Marital Status (circle): M S D W Preferred Language: _____

Race: □ American Indian/Alaska Native □ Asian □ Black/African American

□ Native Hawaiian/Other Pacific Islander □ White □ Unknown

Permanent Address: _____

_____

Local Address During Treatment: _____

_____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Home Phone Number: _____ Cell Phone Number: _____

Employer Information

Employer: _____

Employer Address: _____

_____

Work Phone Number: _____

Retired: (circle one) YES NO Date of Retirement: _____ Income Status: □ Retired with a source of income
□ Retired without a source of income

Have you ever applied for Medicare Disability? YES NO Type: STD LTD Date of Application: _____ Eff. Date: _____

Blood & Marrow Transplant Group of Georgia
Patient Demographic Form

*****Please complete entire form---Do not leave any blanks*****

Physician Information

Referring MD Name: _____ Primary Care Name: _____

Referring MD Number: _____ Primary Care Number: _____

Caregiver Information

1. Name: _____ Relation: _____

Home Phone Number: _____ Cell Phone Number: _____

2. Name: _____ Relation: _____

Home Phone Number: _____ Cell Phone Number: _____

Pharmacy Information

Name:_____ Phone:_____

Primary Insurance Information

Insurance: _____ Insurance Phone #:_____

Subscriber: _____Relationship to Patient: _____ DOB: _____

Employer Name & Address (If different than patient):_____

I.D. #:_____ Group#:_____

Claim Address: _____

Secondary Insurance Information

Subscriber: _____Relationship to Patient_____ DOB_____

Employer Name & Address (If different than patient):_____

Insurance: _____ Insurance Phone #:_____

I.D. #:_____ Group#:_____

Claim Address: _____

Patient Signature: _____Date:_____

PLEASE COMPLETE ENTIRE FORM----DO NOT LEAVE ANY BLANK

REVIEWED BY: _____ REVIEWED DATE_____
(Reviewed by BMTGA staff)

Blood & Marrow Transplant Group of Georgia
Atlanta, GA 30342

PATIENT CONSENT FOR COMMUNICATION/NOTIFICATION
DISCLOSURE OF PROTECTED HEALTH INFORMATION BY BMTGA

I _____ hereby give my consent for **The Blood and Marrow Transplant Group** of Georgia to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **The Blood and Marrow Transplant Group of Georgia's** Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. **The Blood and Marrow Transplant Group of Georgia** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **The Blood and Marrow Transplant Group of Georgia** Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342.

With this consent, **The Blood and Marrow Transplant Group of Georgia** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. With this consent, **The Blood and Marrow Transplant Group of Georgia** may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **The Blood and Marrow Transplant Group of Georgia** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ _____

Signature Date

Blood & Marrow Transplant Group of Georgia

PATIENT AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION TO
THIRD PARTIES
Benefit release for claims/eligibility

_____ _____
Patient's Name Birth Date

_____
Patient's ID#, SSN, or Chart # (Circle One)

_____
Street Address City State Zip

I hereby authorize BMTGA to (check all that apply):

☐ Release to: ☐ verbally only ☐ in written form only ☐ both verbally and in writing

☐ Obtain from the parties I have indicated below.

_____

_____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained. Note: Clinical records used to make benefit determinations may include HIV/AIDS and/or Substance Abuse information.

☐ All pertinent documentation BMTGA deems appropriate for the purpose(s) checked below

☐ Treatment Plan(s)

☐ Office Notes Only

☐ Diagnostic Reports Only

☐ Claims

☐ All records relating to a Disability claim(s)

The purpose of this release is: To allow the clinically appropriate management and coordination of the Patient's health and or coverage under the Patient's health benefit plan (Care Management and Coordination).

☒ Eligibility/Benefits

☒ Benefit Management/ Claims Administration/ Payment

☒ Administration of a Worker's Compensation claim

☒ Administration of a Disability claim

☐ Subpoena or other legal process

☐ Other (describe):

_____

_____

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire**:**

☐ On ____/____/____ (MM/DD/YY), or upon termination of policy coverage, or 60 days after the termination of treatment, whichever is earlier.

OR

☐ Once the following event occurs:

_____

_____

(Form must be completed before signing)

_____

Signature of Patient/Legal Guardian or Patient's Representative — Date

_____

Signature of Minor Patient — Date

_____Print Name of Patient's Representative — Relationship to the Patient

The patient or the person signing this form has the right to receive a copy of this consent form. A copy of this form has been requested and received:

_____ **Yes** _____ **No** **Initials**: _____ (patient)

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations , Parts 160 and 164), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance abuse, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying BMTGA in writing, but if I do, it will not have any effect on any actions BMTGA took before it received the revocation.

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*, with the understanding that this may delay patient care. Signing this form gives BMTGA staff and Northside Hospital Coordinators authorization to obtain or release medically necessary information that is pertinent to your immediate care. Refusal to sign this form may result in the delay of patient care due to insufficient documentation or vital medical information.**

(If you refuse to sign this document please initial and date) Initials:_____ Date:_____

BLOOD & MARROW TRANSPLANT GROUP
OF GEORGIA
5670 PEACHTREE-DUNWOODY ROAD, N.E. • SUITE 1000
ATLANTA, GEORGIA 30342

PHONE: (404) 255-1930 • FAX: (404) 459-8510

Medical Records Release Form/Request Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Georgia law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I hereby authorize this medical Practice, **Blood and Marrow Transplant Group of Georgia**
to release health information of patient named below:

Patient Name: _____ **Date of Birth:** _____

Soc. Sec. #: _____

(Other names, Maiden name): _____

Dates of Service to Release: _____ or _____ **Entire Medical Record**

Reason for Release: _____
(Reason for release must be noted on this form)

Please Print: Send medical records to: (REFERRING PHYSICIAN and/or any other Providers)

Name: _____

_____

_____

Address: _____

_____

_____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (Please initial): Drug/Alcohol_____, Mental Health/Psychiatric_____,

Sexually Transmitted Disease_____, HIV/AIDS_____, Other_____, description of other exclusions:

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPPA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPPA. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that, if records are requested for any other purpose other then continuation of care, claim determination or for the completion of an initial disability application that fees may apply.

Effective July 1, 2006, The Georgia Office of Planning and Budget (OPB) pursuant to O.C.G.A. § 31-33-3, calculates an annual inflation adjustment for the costs related to medical record retrieval, certification and copying. The fee scale determined by BMTGA is as follows,

Search, Retrieval, and Other Direct Administrative Costs	Up to	$24.86
Certification Fee	Up to per record	$9.32
Copying Costs for Records in Paper Form	Per page for pages 1-20	$0.93
	Per page for pages 21 - 100	$0.80
	Per page for pages over 100	$0.63

Refusal to Sign Authorization: I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective this date: _____ thru _____
(dates must be specified)

Signature: _____ **Print Name:** _____

Date: _____

I am the ____ **Patient** ____**Guardian** ____**Conservator** ____**Patient's Representative**
(If this form was completed by someone other than the patient, please print full name.)

Name: _____

I understand that I have the right to receive a copy of this authorization.

The Blood & Marrow Transplant Group
OF GEORGIA

5670Peachtree Dunwoody Rd., Suite 1000, Atlanta, Georgia 30342

In an effort to continuously improve the operations of the Practice, the Clinic has implemented a system to maintain communication throughout the day between all Practice Clinicians and Caregivers. As part of this system, it is necessary to display your name and location in the Clinic during your visit. However, the Clinic wishes to meet your expectations of maintaining your privacy. Please complete the following consent form allowing the Clinic to display your name or request that your name not be displayed.

This consent will be kept on file as long as you are a patient with the Clinic. If at anytime you wish your decision to display your name or not to display your name to be changed, a new consent form can be completed.

During each of my Clinic visits, I understand that Blood & Marrow Transplant of Georgia wants to display my name ("patient") within the clinic setting, as part of an administrative communication system the Clinic utilizes.

I understand the Clinic wishes to meet my expectation of privacy. My wishes are as follows: ***(initial your choice).***

_____ I AGREE to allow the Clinic to display name in the Clinic setting as part of the administrative communication system the Clinic utilizes.

____ I DO NOT want my name to be displayed in the Clinic setting as part of the administrative communication system the Clinic utilizes.

_____ _____

Date Patient

_____ _____

Date Staff Member - Witness

Blood & Marrow Transplant Group of Georgia

BMT PROGRAM AT
NORTHSIDE HOSPITAL

PHOTOGRAPHIC CONSENT AND
AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION
FOR MEDIA OR MARKETING PURPOSES

I authorize Northside Hospital (NSH) and The Blood and Marrow Transplant Group of Georgia (BMTGA) to take photographs or videotapes of me (collectively "photographs"), and to use or disclose those photographs and other information about me, as specifically provided below. I understand that photographs may be considered "protected health information" subject to protection under the federal privacy regulations.

I authorize the individual or organization named above to use or disclose the photographs and other protected health information about me for the following purposes:

- √ use in marketing material that is disseminated within and outside of the Hospital and BMTGA Clinic;
- √ use in press releases and articles disclosed to local or national media
- √ use in articles published in BMT Program at Northside Hospital publications
- √ use in articles or press releases referenced above that also are listed on the NSH or BMTGA web sites
- √ use in broadcast media (TV, radio, news or feature segments)
- √ use in company website

The protected health information about me, other than the photographs, that may be disclosed, is: Name, disease for which your transplant occurred, transplant year.

This authorization is subject to the following additional limitations: _____
_____*(Please write "none" if no additional limitations apply.)*

This authorization to release the photographs or other protected health information about me shall remain valid for ten (10) years from the date of this authorization, unless otherwise noted. _____*(Please insert date or event when authorization will expire.)*

I understand that I can revoke this authorization at any time by submitting a written revocation to:

Blood & Marrow Transplant Group of Georgia
ATT: Compliance Officer
5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, Georgia 30342

I understand that revoking this authorization will have no effect on disclosures that have already occurred before my written revocation is received by NSH and BMTGA. I also understand that once publications that include my photographs or other protected health information have been distributed; those publications cannot be withdrawn from circulation. I understand that once the photographs or other protected health information is released pursuant to this authorization, the information might be redisclosed and no longer protected by the federal privacy regulations.

I understand that NSH & BMTGA will not receive any payment associated with use of this photograph or with release of any other protected health information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at NSH or BMTGA.

_____ _____
Witness Signature of Patient or Legal representative

_____
Relationship to Patient if not the Patient

_____AM/PM
Date/ Time

Original to Medical Records / 1 copy to patient / 1 copy to BMTGA Compliance Officer

BMTGA Caregiver Authorization Form

Patient's Name: _____

Address: _____

Social Security #: _____-_____-_____

Date of Birth: ____/____/____ Gender: ____ Male ____ Female

I agree to allow the caregiver named below access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

☐ release to ☐ verbally only ☐ written form only ☐ both verbally and in writing

Caregiver Name (s): _____
2.)_____
3.)_____
4.)_____

_____ _____
Patient Signature Date Witness Signature Date

Please enter **Caregiver** information below:

Primary Caregiver: _____

Address: _____

_____

Social Security #: _____ (Last 4 digits Only) Date of Birth: ____/____/____

Gender: ____ Male ____ Female

Relationship to patient: _____Son _____ Daughter _____Spouse _____Other

If other, please specify: _____

Additional Caregivers:

Caregiver 2:_____

Caregiver 3:_____

Caregiver 4:_____

PROPER ID REQUIRED PRIOR TO RELEASE OF RECORDS

The Blood and Marrow Transplant Program at Northside Hospital
Atlanta, GA 30342

Infectious Disease Testing Consent
ACKNOWLEDGEMENT OF COUNSELING & CONSENT

Patient Name_____ **MRN** _____

Patient Sex _____ **Race** _____ **Date of Birth** _____

County of Residence _____ **Zip Code** _____

I give my permission for the collection of blood specimens from me (as in other blood tests) to detect whether I have antibodies in my blood to the Human T-Cell Virus Lymphotrophic (HTLV) and/or Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS). A healthcare provider has counseled me regarding the HIV / HTLV antibody test and all my questions regarding the test have been answered. I understand that my blood may also be tested under an investigational research protocol. These tests are explained in attachments to this consent if indicated. I understand that I may be tested periodically under the discretion of my physician for HIV/HTLV and other infectious disease tests. I understand that I may rescind this consent at any time in writing. I understand that Blood & Marrow Transplant Group of Georgia will not release these test results or disclose the fact that I have been tested without my consent unless required or authorized by law. I understand that the results of my blood test will be reported to my doctor who will explain them to me.

I have been given an opportunity to refuse this test and I freely consent to have my blood collected and tested for the HIV / HTLV antibody, and if applicable, other infectious disease testing under an investigational protocol as described above.

If I am consenting on behalf of another, I confirm that I am the patient's parent, legal guardian, or next of kin and that the patient is unable to sign because:
_____

_____ _____
Person Consenting to Test Relationship to Patient if not Parent

_____ _____
Date Witness

BLOOD AND MARROW TRANSPLANT GROUP OF GEORGIA

5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, GA 30342

FINANCIAL POLICY GUIDELINES

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients are required to establish financial arrangements for payment of their account.
- As a courtesy, our practice will establish a reasonable monthly/weekly payment plan to accommodate your needs.
- It should be mentioned that your insurance coverage is an agreement between you and your insurer. Because we participate with many insurance plans, or office will continue to follow all guidelines set forth in our contract with them and provide as much assistance as possible with resolving any problems you may have. However, sometimes when it is dealing with your specific policy, we may not be able to help and it will be up to you to resolve. In that case we will provide guidance if needed.
- Each month you will receive a monthly statement for any personal balances due after insurance processes claims. This balance is due and payable within 30 days. If your payment is late, or arrangements have not already been made, we will mail you a reminder notice indicating that there is a problem with your account. If you are experiencing a set of circumstances out of your control, please contact our practice and we will be happy to make special arrangements.

I acknowledge that I understand and accept this financial policy.

_____ _____

Signature **Date**

_____

Print Name

For your convenience, BMTGA accepts cash, personal checks, Visa, MasterCard, and Discover.

Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342

PATIENT QUESTIONNAIRE

Name: _____ **DOB:** _____ **DATE:** _____

SSN: _____ **Ht:** _____ **Wt.:** _____

GENERAL HEALTH (circle) – Excellent Good Fair Poor

PERSONAL HISTORY:

History of the following:	Yes	No	Comments
Asthma			
Pneumonia			
Tuberculosis			
Diabetes			
Heart Disease			
Hypertension			
Kidney Disease			
Liver Disease			
Thyroid Disease			
Arthritis			
Skin Disease			
Nervous Disorder			
Strokes			
Seizures			
Venereal Disease			
Exposure to Hazardous Chemicals			

Additional Personal History:	Yes	No	Date	Comments
History of Herpes Zoster (Shingles)			/ /	
History of DVTs or Blood Clots			/ /	
Myocardial Infarction			/ /	
CABG			/ /	
Stent placement			/ /	
Cardiomyopathy with EF <40%			/ /	
Valve replacement or repair			/ /	
Multiple Sclerosis				
Myasthenia Gravis				
Muscular Dystrophy				
History of major organ transplant or awaiting transplant			/ /	
Home Oxygen Use			/ /	
Sleep Apnea with or without CPAP			/ /	
History of Difficult Intubations or problems with anesthesia			/ /	

Have you ever tested positive for Hepatitis B, Hepatitis C, HIV or HTLV? Yes No

Other Illnesses, Injuries, and/or Surgeries

	Year	Complications

Dental Assessment: To include last dental exam and condition of oral cavity

Year of last dental exam	Condition of Oral Cavity

Do you or a close relative (brother, sister, mother, father, aunt, uncle, grandparent) have an inherited condition (sickle cell disease or trait, genetic disorder, cystic fibrosis etc.)? Yes_____No_____

If yes, please complete the following information:

Inherited Condition	Treatment	Relationship to You

Do you have a hematological (example hemophilia) or immunological disease (lupus, crohn's disease, rheumatoid arthritis Yes_____No_____

If yes, please complete the following information:

Disease	Year of DX	Treatment

Have you ever been treated for a malignant (Cancer) disease? Yes_____No_____

If yes, please complete the following information:

Type of Cancer	DX Date	Treatment Dates (to include prior transplant)

During previous hospitalizations, have you ever been placed on "CONTACT PRECAUTIONS" or "ISOLATION"? Yes _____No_____

If yes, please circle the reason: VRE MRSA Don't know

Childhood Illnesses:	Yes	No	Year
Measles			
Mumps			
Chicken pox			
Polio			
Rheumatic Fever			
Other:			

Immunizations:	Yes	No	Year
Small Pox			
Tetanus			
Polio			
Hepatitis			
MMR			

Transfusion History:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**	**List meds if yes**
Red Blood Cell Transfusion			Reaction?			Pre-meds required?			
Platelet Transfusion			Reaction?			Pre-meds required?			

Allergies: (List all drugs, foods, tapes, latex, or substances (including albumin), to which you are allergic and specify type of reaction, e.g.: Itching, rash, wheezing, and swelling)

Allergy	**Reaction**

Medications: (List all medications you take regularly, including over the counter, herbal supplements, and vitamins)

Medications	**Amount/Dosage and Frequency per day**

Habits:

Cigarettes: 1. Have you ever smoked cigarettes?	Yes	No	
2. How many years?			Average number of packs of cigarettes per day:
3. Have you smoked cigarettes within the past year?	Yes	No	If no, when did you quit?
Cigars/Pipes	Yes	No	Frequency:
Alcohol	Yes	No	Frequency:
Drugs- Recreational	Yes	No	Type and frequency:
Exercise (type)	Yes	No	Type and Frequency:

FAMILY HISTORY:

History of the following:	Relative(s)	Yes	No	Comments
Asthma				
Pneumonia				
Tuberculosis				
Diabetes				
Heart Disease				
Hypertension				
Kidney Disease				
Liver Disease				
Thyroid Disease				
Arthritis				
Skin Disease				
Nervous Disorder				
Strokes				
Seizures				
Venereal Disease				

FAMILY CURRENT STATUS:

	Age	State of Health
Father		
Mother		
Siblings: (include names)		
Children: (include names)		

Social History:

1. I was born in (city, state or country):
2. What is your ethnicity?
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
3. Race: (Mark the group(s) that apply)

White	**Black or African American**	**American Indian or Alaska Native**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**Decline**
□ Eastern European	□ African (both parents born in Africa)	□ Alaskan Native or Aleut	□ South Asian	□ Guamanian	□ Patient declines to provide race.
□ Mediterranean	□ African American	□ North American Indian	□ Filipino (Pilipino)	□ Hawaiian	
□ Middle Eastern Coast	□ Black Caribbean	□ Caribbean Indian	□ Japanese	□ Samoan	
□ North Cost of Africa	□ Black South or Central American		□ Korean	□ Other Pacific Islander	
□ North American			□ Chinese		
□ Northern European			□ Vietnamese		
□ Western European			□ Other Southeast Asian		
□ White Caribbean					
□ White South or Central American					
□ Other White					

1. Please circle one: Single Married Widowed Divorced
2. Education: Please indicate highest level of education:
3. Are you currently in school or were you enrolled in school prior to your illness? Yes ___No___
4. Occupation: (To include any military service)
5. What is your current or most recent work status prior to your illness?

   □ Full time □ Part time □ Unemployed □ Medical Disability □ Retired
6. Hobbies:
7. Travel History: (Outside of the USA) Please list places and dates of travel.

REVIEW OF SYSTEMS:

General:	Yes	No	Date of Onset (if unknown, leave blank)	Comments
Weakness			/ /	
Tiredness			/ /	
Pain			/ /	
Appetite changes			/ /	
Weight change			/ /	
Chills			/ /	
Fevers			/ /	
Night Sweats			/ /	
HEENT:				
Visual changes			/ /	
Hearing changes			/ /	
Nosebleeds			/ /	
Sinus problems			/ /	
Hoarseness			/ /	
Neck pain			/ /	
Dental problems			/ /	
Bleeding gums			/ /	
Respiratory:				
Cough			/ /	
Cough up blood			/ /	
Wheezing			/ /	
Shortness of breath at rest			/ /	
Shortness of breath with activity			/ /	
Cardiovascular:				
Chest pain			/ /	
Shortness of breath when lying flat			/ /	
Palpitations (irregular heart beat)			/ /	
Heart murmur			/ /	
Leg swelling			/ /	
Leg pain			/ /	
Blue/purple discoloration hands or feet			/ /	
Breasts:				
Monthly self-breast exam			/ /	
Lumps			/ /	
Pain			/ /	
Nipple discharge			/ /	
Gastrointestinal:				
Nausea			/ /	
Vomiting			/ /	
Diarrhea			/ /	
Constipation			/ /	
Change in bowel pattern			/ /	
Heart burn			/ /	
Abdominal pain			/ /	
Bright red blood in stools			/ /	
Black stools			/ /	
Hemorrhoids			/ /	
Urinary:				
Urinary tract infections			/ /	
Pain/burning on urination			/ /	
Frequent urination			/ /	
Difficulty starting/stopping stream			/ /	
Kidney stones			/ /	

REVIEW OF SYSTEMS: (continued)

Genito-reproductive: Male	Yes	No	Date of Onset (if unknown, leave blank)	Comments
Discharge from penis			/ /	
Testicular pain			/ /	
Lumps in testicles or scrotum			/ /	
Decrease in testicular size			/ /	
Decreased sexual desire			/ /	
Decreased ability to achieve erection			/ /	
Genito-reproductive: Female				
Age of onset of periods:			/ /	
Age of menopause:			/ /	
Bleeding between periods			/ /	
Last normal period			/ /	
Do you have vaginal discharge			/ /	
Does intercourse cause pain			/ /	
Do you have decreased sexual desire			/ /	
Do you have hot flashes			/ /	
Are you taking female hormones			/ /	
Last pap smear			/ /	
Pregnancies, number:			N/A	
Number of live births:			N/A	
Musculoskeletal:				
Painful/stiff joints			/ /	
Swollen joints			/ /	
Muscle pain			/ /	
Back pain			/ /	
Endocrine:				
Heat/cold intolerance			/ /	
Tremulousness of hands			/ /	
Changes of body hair			/ /	
Increased thirst			/ /	
Increased urination			/ /	
Neurologic/Psychiatric:				
Depression			/ /	
Difficulty with sleep			/ /	
Memory changes			/ /	
Headaches			/ /	
Blackouts/Dizziness			/ /	
Weakness of limbs			/ /	
Numbness/tingling of limbs			/ /	
Loss of coordination/balance			/ /	
Skin:				
Dryness			/ /	
Rash/itching			/ /	
Changes in skin color			/ /	
Poor healing sores			/ /	
Easy bruising			/ /	
Nail changes			/ /	
Hair changes			/ /	

☐ Yes, I confirm all information I have provided is true to the best of my knowledge.

Patient Signature: _____Date: _____

Please do not complete this section. To be completed by Mid-level/BMT Physician

Please circle **ANY** definition that applies to Recipient/Donor and document date of onset.

Co-Existing DX	Definition
Arrhythmia	Atrial fibrillation or flutter, sick sinus syndrome or ventricular Arrhythmias **Date of onset:**
Cardiac	Coronary Artery Disease, congestive heart failure, myocardial infarction, or EF <50%; HTN Date **of onset:**
CNS	Transient ischemic attack, cerebrovascular accident, paralysis, meningitis/encephalitis, seizure disorder, stroke or CVA Date **of onset:**
Chromosome	Downs Syndrome, Fanconi anemia **Date of onset:**
Endocrine	Diabetes, (requiring treatment with insulin or oral hypoglycemics but not diet alone) Adrenal insufficiency, osteoporosis, thyroid disease **Date of onset:**
Heart Valve Disease	Except mitral valve prolapse **Date of onset:**
Hematologic	DVT, PE **Date of onset:**
Hemorrhage; Significant	GI/GU/CNS **Date of onset:**
Hepatic, mild	Chronic hepatitis, bilirubin. ULN to 1.5 X AST/ALT > ULN to 2.5 X ULN **Date of onset:**
Hepatic, moderate/severe	Liver cirrhosis, bilirubin > 1.5 X ULN, or AST/ALT > 2.5 X ULN **Date of onset:**
Infection	Requiring continuation of antimicrobial treatment Date **of onset:**
Gastrointestinal	Inflammatory Bowel Disease; Crohn's disease, ulcerative colitis, PUD, GERD **Date of onset:**
Obesity	Patients with a body mass index > 35 kg/m2 **Date of onset:**
Psychiatric disturbance	Depression or anxiety requiring psychiatric consult or treatment **Date of onset:**
Pulmonary, moderate	DLCO and/or FEV1 66-80% or dyspnea on slight activity; asthma, restrictive lung disease **Date of onset:**
Pulmonary, severe	DLCO and/or FEV1, < 65% or dyspnea at rest or required oxygen; COPD **Date of onset:**

Please do not complete this section. To be completed by Mid-level/BMT Physician

Please circle **ANY** definition that applies to Recipient/Donor and document date of onset.

Renal, moderate/severe	Serum creatinine > 2 mg/dL or > 177 umol/L, on dialysis, or prior renal transplantation **Date of onset:**
Auto Immune	SLE, RA, polymyositis, mixed CID, or polymyalgia/rheumatica, MS, psoriasis **Date of onset:**
Solid Tumor, prior	Treated at any time point in the patients' past history, excluding non-melanoma skin cancer. Please document year of diagnosis. **Date of onset:**

Mid-Level Signature: _____ DATE: _____

BMT Physician Signature: _____ DATE: _____