# Tri-Valley Oncology / Hematology
## Ashwin Kashyap, M.D.
## 555 Marin St., Suite 200, Thousand Oaks, CA 91360

DATE_____ DATE OF FIRST INJURY OR ILLNESS_____

NAME_____ DATE OF BIRTH_____

ADDRESS_____ M_____F_____ AGE_____

_____MARITAL STATUS_____

CITY STATE ZIP CODE

HOME PHONE NUMBER _(____)_____ WORK PHONE NUMBER_(____)_____

CELLULAR PHONE NUMBER (  ) _____ EMAIL ADDRESS _____

PATIENT'S SOCIAL SECURITY NUMBER_____-_____-_____

PATIENT'S DRIVER'S LICENSE NUMBER_____

OCCUPATION_____

EMPLOYER_____

EMPLOYER'S ADDRESS_____

_____

CITY STATE ZIP CODE

REFERRING/PRIMARY CARE PHYSICIAN _____

SPOUSES' NAME _____ SOCIAL SECURITY #_____-_____-_____

SPOUSES' EMPLOYER_____WORK PHONE NUMBER_(___)_____

SPOUSES' DATE OF BIRTH_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:_____

ADDRESS_____PHONE NUMBER_____

_____

CITY STATE ZIP CODE

IF PATIENT IS A MINOR, WHO IS LEGALLY RESPONSIBLE?_____
RELATIONSHIP (i.e. mother, father, legal guardian)

**INSURANCE INFORMATION !!!!!!! PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST SO COPIES CAN BE MADE.**

PRIMARY INSURANCE CARRIER_____

GROUP #_____ I.D. OR SUBSCRIBER # _____

INSUREDS NAME_____INSUREDS Social Security_____

BILLING ADDRESS_____INSUREDS DATE OF BIRTH_____

SECONDARY INSURANCE CARRIER_____

GROUP #_____ I.D. OR SUBSCRIBER #_____

INSUREDS NAME_____INSUREDS Social Security_____

INSUREDS Date of birth_____

**TRI-VALLEY ONCOLOGY HEMATOLOGY**

**ASHWIN KASHYAP, M.D.**
**555 MARIN ST., SUITE 200**
**THOUSAND OAKS, CA 91360**
**PHONE: (805) 496-0592**
**FAX: (805) 494-1017**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ABOVE NAMED PHYSICIAN OF THE MEDICAL BENEFITS IF ANY. IN THE EVENT THE INSURANCE PAYS BENEFITS DIRECTLY TO ME I WILL BE RESPONSIBLE FOR PAYING BENEFITS TO THE ABOVE PHYSICIAN.

_____ DATE_____

SIGNATURE OF INSURED

**PAYMENT OF SERVICES**

ALL DEDUCTIBLES, COINSURANCE AND COPAYS ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND AS A COURTESY TO ME, MY INSURANCE WILL BE BILLED. IF INSURANCE PAYS MORE THAN ESTIMATED AT THE TIME OF SERVICE, I WILL BE ENTITLED TO A REFUND AFTER ANY BALANCES ARE CLEARED IN MY ACCOUNT.

_____ DATE_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

**AUTHORIZATION TO RELEASE INFORMATION**

I HEREBY AUTHORIZE ABOVE NAMED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY SPOUSE/ SIGNIFICANT OTHER.

_____ DATE_____

SIGNATURE OF PATIENT OR PARENT IF MINOR

DATE_____

**RECORDS RELEASE**

TO (DR. OR HOSPITAL)_____

ADDRESS_____ PHONE NUMBER _(____)_____

_____

CITY STATE ZIP CODE

I HEREBY AUTHORIZE YOU TO RELEASE TO

ASHWIN KASHYAP, M.D
555 MARIN ST. # 200
THOUSAND OAKS, CA 91360
PHONE: (805) 496-0592 FAX: (805) 494-1017

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, (WHICH INCLUDE ALL HISTORY, PHYSICAL, LAB, X-RAY, EKG'S SCANS AND DISCHARGE) CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE TIME YOU TREATED ME.

_____ _____

SIGN PRINT

WITNESS_____ RELATIONSHIP_____

# Current Attending Physicians

Patient Name: _____

1. Physicians Name _____ Address _____

Specialty _____ Phone # (____)_____ Fax # (____)_____

2. Physicians Name _____ Address _____

Specialty _____ Phone # (____)_____ Fax # (____)_____

3. Physicians Name _____ Address _____

Specialty _____ Phone # (____)_____ Fax # (____)_____

4. Physicians Name _____ Address _____

Specialty _____ Phone # (____)_____ Fax # (____)_____

5. Physicians Name _____ Address _____

Specialty _____ Phone # (____)_____ Fax # (____)_____

TRI-VALLEY
ONCOLOGY & HEMATOLOGY
INDIVIDUALIZED CARE

Ashwin Kashyap, MD, FACP


PATIENT NAME _____

PHARMACY _____

PHONE # (___)_____

FAX # (___)_____ (OPTIONAL)

PHARMACY _____

PHONE # (___)_____

FAX # (___)_____ (OPTIONAL)

**Thousand Oaks**
555 Marin St., Suite 200
Thousand Oaks, CA 91360
Ph:(805) 496-0592 Fax:(805) 494-1017

**Simi Valley**
2045 Royal Ave, Suite 208
Simi Valley, CA 93065
Ph: (805)581-7000 Fax(805)581-7003

## ASHWIN KASHYAP, M.D.

## PATIENT HISTORY QUESTIONNAIRE

DATE_____

NAME_____AGE_____ MARITAL STATUS_____

MALE_____ FEMALE_____RACE_____ETHNICITY Hispanic or Latino_____not-hispanic or Latino_____

PREFERRED LANGUANGE_____

**FAMILY HISTORY**

| | FATHER | MOTHER | SIBLINGS | SELF |
|---|---|---|---|---|
| AGE | | | | |
| LIVING/DEAD | | | | |

**INDICATE ILLNESS FOR YOUR SELF BY YES OR NO**

TUBERCULOSIS _____

DIABETES _____

CANCER _____

HEART DISEASE _____

HYPERTENSION _____

LUNG DISEASE _____

KIDNEY DISEASE _____

ARTHRITIS _____

**OTHER** (MAJOR ILLNESS OR SURGERY)

OTHER:_____

ADDITIONAL NOTES:_____

_____

_____

_____

**SOCIAL HISTORY**
PLEASE INDICATE BY YES OR NO

CIGARETTE SMOKER _____ NON-SMOKER_____ FORMER SMOKER_____

IF YOU ARE A SMOKER OR FORMER SMOKER:

AGE STARTED_____ AGE STOPPED_____

AVERAGE PACKS/DAY_____ PACKS/YEARS (PHYSICIAN ONLY)_____

ALCOHOL (IF PERTINENT, PLEASE INDICATE DEGREE OF ALCOHOL INTAKE)

_____

_____

OTHERS

COFFEE OR TEA (NUMBER OF CUPS PER DAY) _____

MARIJUANA, HEROIN, LSD OR SIMILAR DRUGS:

_____

_____

_____

**PAST HISTORY**

PAST SURGICAL HISTORY (PLEASE INDICATE HOSPITALIZATIONS)

| HOSPITALIZATION ( REASON) | MONTH | YEAR | HOSPITAL | CITY/STATE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

OTHER PERTINENT INFORMATION

_____

_____

_____

**PAST MEDICAL HISTORY** (NOT REQUIRING HOSPITALIZATION)

| PROBLEM | NATURE OF ILLNESS |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

OTHER PERTINENT INFORMATION

MEDICATIONS (**LIST EVERYTHING YOU TAKE AND HOW OFTEN, INCLUDING VITAMINS, BIRTH CONTROL PILLS, ect.**)

ALLERGIES TO ANY MEDICATIONS (**LIST ALL DRUGS AND NATURE OF THE ALLERIC REACTION**)

## REVIEW OF SYSTEMS

PLEASE INDICATE WITH A CHECK ONLY IF THIS IS A PRESENTLY OR HAS BEEN IN THE PAST A PROBLEM.

**HEAD, EYES, EARS, NOSE, AND THROAT**

FREQUENT HEADACHES _____
NECK PAINS _____
NECK LUMPS OR SWELLING _____
BLURRY VISION _____
EYESIGHT WORSENING _____
SEE DOUBLE _____
SEE HALOS _____
EYE PAINS OR ITCHING _____
WATERING EYES _____
EYE TROUBLE _____
HEARING DIFFICULTIES _____
EARACHES _____
RUNNING EARS _____
RINGING IN EARS _____

CONGESTED NOSE _____
OBSTRUCTION _____
RUNNING NOSE _____
SNEEZING SPELLS _____
HEAD COLDS _____
NOSE BLEEDS _____
SORE THROAT _____
ENLARGED TONSILS _____
HOARSE VOICE _____

DENTAL PROBLEMS _____
SWELLING ON GUMS OR JAWS _____
BLEEDING GUMS _____
DENTURES _____
SORE TONGUE _____
TASTE CHANGES _____

**CARDIORESPIRATORY**

WHEEZES OR GASPS _____
COUGHING SPELLS _____
COUGHS UP PHLEGM _____
COUGHED UP BLOOD _____
CHEST COLDS _____
PNEUMONIA _____
TUBERCULOSIS _____
ASTHMA _____
BLOOD CLOTS IN LUNGS _____

EXCESSIVE SWEATING, NIGHT _____
HEART DISEASE _____
HIGH BLOOD PRESSURE _____
RHEUMATIC FEVER _____
RACING HEART _____
CHEST PAIN _____
DIZZY SPELLS _____
SHORTNESS OF BREATH _____
SHORTNESS OF BREATH, NIGHT _____
MORE PILLOWS TO BREATHE _____
SWOLLEN FEET OR ANKLES _____
LEG CRAMPS _____
HEART MURMUR _____

**GASTROINTESTINAL**

HEARTBURN _____
BLOATED STOMACH _____
BELCHING _____
STOMACH PAINS _____
HISTORY OF ULCERS _____
PANCREATITIS _____
NAUSEA _____
VOMITED BLOOD _____
JAUNDICE &/OR HEPATITIS _____
DIFFICULTY SWALLOWING _____
CONSTIPATION _____
LOOSE BOWELS _____
BLACK STOOLS _____
GREY STOOLS _____
PAIN IN RECTUM _____
RECTAL BLEEDING _____

**GENITOURINARY**

NIGHT FREQUENCY _____
DAY FEQUENCY _____
BURNING IN URINATION _____
PAIN DURING URINATION _____
BROWN, BLACK OR BLOODY URINE _____
DIFFICULTY STARTING URINE _____
URGENCY _____
STONES _____
VENEREAL DISEASE _____

WEAK URINE STREAM _____
PROSTATE TROUBLE _____
BURNING OR DISCHARGE _____

**NEURO-PSYCH**

FAINTNESS _____

LUMPS ON TESTICLES _____
PAINFUL TESTICLES _____

MENSTRUAL TROUBLE _____
BREAKTHROUGH BLEEDING _____
HEAVY BLEEDING _____
BLEEDING AFTER INTERCOURSE _____
PAIN WITH INTERCOURSE _____
PREMENTRUAL TENSION _____
HOT FLASHES _____
BIRTH CONTROL PILLS _____
LUMPS IN BREASTS _____
PAIN OR TENDERNESS IN BREASTS _____
NIPPLE DISCHARGE _____
VAGINAL DISCHARGE _____
PAP SMEAR _____
LAST MENSTRUAL PERIOD _____
MENOPAUSE _____

No. OF NORMAL PREGNANCIES _____
No. OF NORMAL DELIVERIES _____
MISCARRIAGES _____
STILLBIRTHS _____
PREMATURE BIRTHS _____
CESAREANS _____
ABORTIONS _____

**CONNECTIVE TISSUE**

ACHING MUSCLES OR JOINTS _____
SWOLLEN JOINTS _____
BACK OR SHOULDER PAINS _____
PAINFUL FEET _____

SKIN PROBLEMS _____
ITCHING OR BURNING SKIN _____
BLEEDING EASILY _____
BRUISES EASILY _____

NUMBNESS _____
CONVULSIONS _____
PARALYSIS _____
CHANGE IN HANDWRITING _____
TREMBLES _____

LACK OF CONSENTRATION _____
LACK OF MEMORY _____

HOPELESS OUTLOOK _____
WORK OF FAMILY PROBLEMS _____
SEXUAL DIFFICULTIES _____
CONSIDERED SUICIDE _____
DESIRED PSYCHIATRIC HELP _____

**ENDOCRINE**

WEIGHT CHANGES _____
TENDS TO BE HOT OR COLD _____
LOSS OF INTEREST IN EATING _____
ALWAYS HUNGRY _____
MORE THIRSTY LATELY _____
FATIGUE _____
SLEEPING DIFFICULTIES _____

**PHYSICIAN NOTES RELATING TO ABOVE SYSTEMS**

# HEREDITARY CANCER QUESTIONNAIRE

## Personal Information

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

**Gender (M/F):** _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

**Instructions:** This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** *You, Parents, Brothers, Sisters, Sons, Doughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

## YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

| | CANCER | YOU AGE OF Diagnosis | PARENTS / SIBLINGS / CHILDREN | AGE OF Diagnosis | RELATIVES on your MOTHER'S SIDE | AGE OF Diagnosis | RELATIVES on your FATHER'S SIDE | AGE OF Diagnosis |
|---|---|---|---|---|---|---|---|---|
| ☑Y ☐N | *EXAMPLE: BREAST CANCER* | *45* | — | — | *Aunt Cousin* | *45 61* | *Grandmother* | *53* |
| ☐Y ☐N | BREAST CANCER *(Female or Male)* | | | | | | | |
| ☐Y ☐N | OVARIAN CANCER *(Peritaneal/Fallopian Tube)* | | | | | | | |
| ☐Y ☐N | UTERINE (ENDOMETRIAL) CANCER | | | | | | | |
| ☐Y ☐N | COLON/RECTAL CANCER | | | | | | | |
| ☐Y ☐N | 10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)* | | | | | | | |
| ☐Y ☐N | OTHER CANCER(S) *(Specify cancer type)* | Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid* | | | | | | |

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

## Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

| | | |
|---|---|---|
| ☐ | **Multiple** A combination of cancers on the same side of the family: | ○ **2 or more**: breast / ovarian / prostate / pancreatic cancer<br>○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)<br>○ **2 or more**: melanoma / pancreatic |
| ☐ | **Young** Any 1 of the following at age **50 or younger**: | ○ Breast cancer<br>○ Colorectal cancer<br>○ Endometrial cancer |
| ☐ | **Rare** Any 1 of these rare presentations at **any age**: | ○ Ovarian cancer<br>○ Breast: Male breast cancer or Triple negative breast cancer<br>○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology††<br>○ Endometrial cancer with abnormal MSI/IHC<br>○ 10 or more gastrointestinal polyps* |

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

*Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

## Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

**For Office Use Only:** Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____