Dear Patient,

Welcome to the Cancer Center at Hackensack University Medical Center. We are sending you this pertinent information in order to facilitate your initial visit to our Center. We have enclosed directions to our location from several different areas.

*The new address of our office is **92 Second Street, Hackensack, NJ 07601**.*

Complimentary parking is available for your convenience. There are 2 dedicated patient parking garages. The 1st is located under the building where you can access from First Street. The 2nd is located directly across from the main entrance on Second Street.

- *When you enter the building, please approach the Guest Service desk and give your name to the receptionist.*
- *Please bring your insurance card, any pertinent insurance forms and have your driver's license with you.*
- *Co-payment is expected at the time of your visit, one for your physician and one for Hackensack University Medical Center.*
- *If your insurance company requires a referral, please bring two referrals, one for your physician and one for Hackensack University Medical Center.*
- *The registration office will review this information with you.*
- *Please be advised that the bill will become your responsibility without a valid referral.*

After you have signed in for your physician visit, you will be escorted to our Registration office to register and sign paperwork. Once you are registered, you will be escorted to the Laboratory for initial blood work and to floor where your doctor practices. Please check-in at the reception desk. At this time, you may pay your copayment, if applicable and then may take a seat in our comfortable waiting room.

Once your lab work has been processed, you will be taken into see the doctor. Please be aware that the entire process may take up to two hours.

If applicable, please remember to bring your films and slides with you at the time of your visit.

We, at The Cancer Center, want you to know that we consider your health care to be our top priority. Please feel free to ask any questions. If you need further information, please call us at (201) 996-5900.

HACKENSACK UNIVERSITY MEDICAL CENTER
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Social Security Number
Address (Street, City, State, Zip Code)		Telephone Number

The following individual or organization is authorized to make the disclosure:
Hackensack University Medical Center and Regional Cancer Care Associates, LLC.

This information may be disclosed to and used by the following individual or organization:
Hackensack University Medical Center and Regional Cancer Care Associates, LLC.

Treatment dates: Past, current and future medical records as needed to provide your care

Purpose of Request: To provide you with the highest quality of care.

The following information is to be disclosed:

Discharge Summary
History & Physical Examination
Consultations (including psychiatric evaluations)
Operative Report or Procedure Reports
Emergency Department Record
Laboratory Reports (including drug screens)
Radiology or Imaging Reports
Cardiac Studies
Interdisciplinary Records (Progress Notes)
Medication Records
Nursing Notes
Physician Orders
Complete Record
Other ______________________________

Please list all family members and friends to whom Information may be released to on the lines below:

____

____

____

____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire at the end of your course of treatment.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the Systems Manager in the Health Information Management Department at 201-996-2075.

Signature of Patient or Legal Representative   Date

If Signed by Legal Representative, Relationship to the Patient

DON IMUS/WFAN Pediatric Center for Tomorrows Children

Railroad Parking Garage

DON IMUS/WFAN Parking

Hillcrest Building

Hekemian Conference Center

Employee Parking Garage

Jeffrey M. Creamer Trauma Center/ Emergency Department

The Audrey Hepburn Children's House

The MOLLY Diabetes Center for Adults
211 Essex Street
Suite 101
Hackensack, NJ 07601

John Theurer Cancer Center

Future site of the Atlantic Street Parking Garage

The Sarkis and Siran Gabrellian Child Care and Learning Center

First Street Polifly Rd →

Johnson Hall

Patient Pavilion

Second Street

Visitor Parking Garage

Atlantic Street

Essex Street

Hackensack University Medical Plaza
20 Prospect Avenue
with Valet Parking

Hackensack University Medical Center
Programs located within
The Alfred N. Sanzari Medical Arts Building
360 Essex Street

	Suite
Dermatologic, Laser, and Mohs Surgery Center	201
Physical Medicine and Rehabilitation	202
The Center for Occupational Medicine	203
The Hackensack University Medical Center Foundation	301
The Cancer Center at The Alfred N. Sanzari Pavilion	302
The Institute for Breast Care Surgical Center	303
Orthopaedic Surgery and Sports Medicine	303
Organ Transplantation	401
The Center for Pediatric Gastroenterology and Nutrition	402
Department of Urology	403
The Continence Center	403

Emil Buehler Helipad

The Creamer Family Institute for Medical Imaging

Parking Entrance for:
- The Jeffrey M. Creamer Trauma Center/ Emergency Department
- The Sarkis and Siran Gabrellian Women's and Children's Pavilion

The Sarkis and Siran Gabrellian Women's and Children's Pavilion
Home to:
- The Joseph M. Sanzari Children's Hospital
- The Donna A. Sanzari Women's Hospital
- The Mark Messier Skyway for Tomorrows Children

Prospect Avenue

George Link Jr. Pavilion

David Joseph Jurist Research Center for Tomorrows Children

Medical Center Entrance & Visitor Parking

Dr. John Apovian Admission Services Center

Thompson Street

Summit Avenue

JOHN THEURER CANCER CENTER
92 SECOND STREET
HACKENSACK, NJ 07601
(201) 996-5900

FROM GEORGE WASHINGTON BRIDGE EAST
Follow Route 80 West, staying local lanes, to Exit 64 B. Turn right onto Polifly Road and travel north on Polifly Road. At second light, turn left onto Essex Street. Make your first right onto Second Street. Continue straight on Second Street and # 92 is on your right hand side.

FROM PATERSON AREA AND WEST
Follow Route 80 East, staying in local lanes to Exit 63 B for Rochelle Park and Paramus. (Exit ramp sign says Exit 63.) Turn left off exit ramp, and turn right at light onto Essex Street. Follow Hospital Signs. At fourth light, turn left onto Prospect Avenue. Pass the Hackensack University Medical Center on your right and proceed to your first street, Atlantic Street, and make a right. Continue downhill to Second Street, make left and # 92 is immediately on the right.

FROM SOUTHERN NEW JERSEY VIA THE NEW JERSEY TURNPIKE
Follow Route 95-NJ Turnpike north to the junction of Route 80. Take 80 west, stay in lanes for "Local Exits" to Exit 64 B for Hasbrouck Heights and Newark. Turn right at light on Polifly Road. At second light, turn left onto Essex Street. Make your first right onto Second Street. Continue straight on Second Street and # 60 is on your right hand side.

FROM SOUTHWESTERN NEW JERSEY ON ROUTE 17
Follow Route 17 North to Polifly Road turnoff. Go under the Route 80 overpass and turn left at the second light onto Essex Street. Make your first right onto Second Street. Continue straight on Second Street and # 92 is on your right hand side.

FROM NORTHWESTERN NEW JERSEY ON ROUTE 17
Follow Route 17 South to Essex Street exit. Turn left onto Essex Street. At fourth light, turn left onto Prospect Avenue. Pass the Hackensack University Medical Center on your right and proceed to Atlantic Street, and make a right. Continue downhill to Second Street, make left and # 92 is immediately on the right.

FROM THE LINCOLN TUNNEL
Take Route 3 West to Route 17 North. Proceed on Rt 17N to Essex Street exit. Make a right onto Essex Street. At fourth light, turn left onto Prospect Avenue. Pass the Hackensack University Medical Center on your right and proceed to your first street, Atlantic Street, and make a right. Continue downhill to Second Street, make left and # 92 is immediately on the right.

FROM THE GARDEN STATE PARKWAY
From the Garden State Parkway (north or south), take Route 80 East (Exit 159). Follow Route 80 East, staying in local lanes, to Exit 63 B for Rochelle Park and Paramus. (Exit ramp sign says Exit 63.) Turn left off exit ramp, and turn right onto Essex Street. Follow Hospital signs. At fourth light, turn left onto Prospect Avenue. Pass the Hackensack University Medical Center on your right and proceed to your first street, Atlantic Street, and make a right. Continue downhill to Second Street, make left and # 92 is immediately on the right.

WHEN YOU ARRIVE.........
Complementary parking is available for you under the building or across Second Street, in the Cancer Center Parking Lot.

Valet parking is available in front of JTCC main entrance on Second Street for a fee unless handicapped registration is presented.

You can either enter the building from our underground parking or using our Second Street entrance.

NEW PATIENT INFORMATION FORM

Today's Date: ________________

Patient Name: ______________________________ M.I. ________ Date of Birth: ________________

Address: ______________________________ City: ____________ State: _____ Zip: ____________

Home #: ____________________ Work #: ____________________ Cell #: ____________________

HISTORY OF PRESENT ILLNESS / DIAGNOSIS:

Location: __________________________________
(Where is the pain / problem?)

Description: __________________________________
(Examples: Color of Sputum)

Severity: __________________________________
(How severe is the pain / problem?)

Duration: __________________________________
(How long have you had this – when did it start?)

Timing: __________________________________
(Does the pain / problem occur at a specific time?)

Context: __________________________________
(Where were you at the onset of this pain / problem?)

Associated Signs/ Symptoms: __________________________________
What other problems have you been having?

Modifying Factors: __________________________________
What makes the pain / problem worse or better? *Or have you had any previous episodes?*

MEDICAL HISTORY:

PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES – When? ______________________________

____

____

____

Have You Ever Had The Following? Please Circle YES or NO

Diabetes	Yes	No	Stroke	Yes	No	Gout	Yes	No	Active Infections ...	Yes	No
Hypertension	Yes	No	Heart Trouble	Yes	No	Convulsions	Yes	No	Hereditary Defects	Yes	No
Cancer	Yes	No	Arthritis	Yes	No	Bleeding Tendency	Yes	No	Other ________________		

PATIENT SOCIAL HISTORY:

Marital Status:	Use of Alcohol:	Use of Tobacco:	Use of Drugs:	Excessive Exposure at Home or Work to:
Single	Never	Never	Never	Fumes ________________
Married	Rarely	Previously But Quit	Type & Frequency	Solvents ________________
Divorced	Moderate	Currently	________________	Chemicals ________________
Widowed	_____ Daily	_____ Packs Daily	________________	Other ________________

FAMILY MEDICAL HISTORY:

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
FATHER:	________	______________________________	______________________________
MOTHER:	________	______________________________	______________________________
BROTHERS:	________	______________________________	______________________________
	________	______________________________	______________________________
SISTERS:	________	______________________________	______________________________
	________	______________________________	______________________________
SPOUSE:	________	______________________________	______________________________
CHILDREN:	________	______________________________	______________________________

SYSTEM REVIEW

RESPIRATORY

Item		
Chronic or Frequent Cough	Yes	No
Spitting Up Blood	Yes	No
Shortness Of Breath	Yes	No
Asthma or Wheezing	Yes	No

PSYCHIATRIC

Item		
Memory Loss or Confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

EYES

Item		
Eye Disease or Injury	Yes	No
Wear Glasses / Contact Lenses	Yes	No
Blurred or Double Vision	Yes	No
Glaucoma	Yes	No

HEMATOLOGIC / LYMPHATIC

Item		
Slow to Heal After Cuts	Yes	No
Bleeding or Bruising Tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past Transfusion	Yes	No
Enlarged Glands	Yes	No

CONSTITUTIONAL SYMPTOMS

Item		
Good General Health Lately	Yes	No
Recent Weight Change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

CARDIOVASCULAR

Item		
Heart Trouble	Yes	No
Chest Pain	Yes	No
Angina	Yes	No
Palpitations	Yes	No
Shortness of Breath while Walking or Lying	Yes	No
Swelling if feet or Ankles	Yes	No

MUSCULOSKELETAL

Item		
Joint Pain	Yes	No
Joint Stiffness or Swelling	Yes	No
Weakness of Muscles or Joints	Yes	No
Muscle Pain or Cramps	Yes	No
Back Pain	Yes	No
Cold Extremities	Yes	No
Difficulty Walking	Yes	No

INTEGUMENTARY

Item		
Rash or Itching	Yes	No
Change in Skin Color	Yes	No
Chain in Hair or Nails	Yes	No
Varicose Veins	Yes	No
Breast Pain	Yes	No
Breast Lump	Yes	No
Breast Discharge	Yes	No

ENDOCRINE

Item		
Glandular or Hormone Problems	Yes	No
Thyroid Disease	Yes	No
Diabetes	Yes	No
Excessive Thirst or Urination	Yes	No
Heat or Cold Intolerance	Yes	No
Skin Becoming Dryer	Yes	No
Change in Hat or Glove Size	Yes	No

EARS, NOSE, MOUTH & THROAT

Item		
Hearing Loss or Ringing	Yes	No
Earaches or Drainage	Yes	No
Chronic Virus Problems or Rhinitis	Yes	No
Nose Bleeds	Yes	No
Mouth Sores	Yes	No
Bleeding Gums	Yes	No
Bad Breath or Bad Taste	Yes	No
Sore Throat or voice Change	Yes	No
Swollen Glands in Neck	Yes	No

GASTROINTESTINAL

Item		
Loss of Appetite	Yes	No
Change in Bowel Movements	Yes	No
Neusea or Vomiting	Yes	No
Frequent Diarrhea	Yes	No
Painful Bowel Movements or Constipation	Yes	No
Rectal Bleeding or Blood in Stool	Yes	No
Abdominal Pain or Heartburn	Yes	No
Peptic Ulcer (Stomach or Duodenal)	Yes	No

NEUROLOGICAL

Item		
Frequent or Recurring Headaches	Yes	No
Light Headed or Dizzy	Yes	No
Convulsions or Seizures	Yes	No
Numbness or Tingling Sensation	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head Injury	Yes	No

GENITOURINARY

Item		
Frequent Urination	Yes	No
Burning or Painful Urination	Yes	No
Blood in Urine	Yes	No
Change in Force of Stream when Urinating	Yes	No
Incontinence or Dribbling	Yes	No
Kidney Stones	Yes	No
Sexual Difficulties	Yes	No
Male – Testicular Pain	Yes	No
Female – Pain with Periods	Yes	No
Female – Irregular Periods	Yes	No
Female – Vaginal Discharge	Yes	No

Item	
Female – Number of Pregnancies	____________
Female – Number of Miscarriages	____________
Female – Date of Last Pap Smear	____________
Female – First Menstrual Period	____________
Female – Last Menstrual Period	____________
Oral Contraceptive Pills	____________
Hormone Replacement Therapy	____________

ALLERGIC / IMMUNOLOGIC

History of Skin Reaction or Adverse Reaction To:

Item		
Penicillin or Other Antibiotics	Yes	No
Morphine, Demerol or Other Narcotics	Yes	No
Novocaine or Other Anesthetics	Yes	No
Aspirin or Other Pain Remedies	Yes	No
Tetanus Antitoxins or Other Serums	Yes	No
Iodine, Methiolate or Other Antiseptics	Yes	No
Other Drugs / Medicines	Yes	No
Known Food Allergies	Yes	No

If you Answered Yes To Any Questions, Explain Below or on Back of this Sheet:

____

____

____

____

____

____

____

PLEASE INFORM THE DOCTOR OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING
(Including ASPIRIN)

	Medication Name	Strength (i.e. mgs, etc)	Dosage (i.e. amount & when taken)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

Please inform us of all physicians you are currently seeing.

Physician Name: ______________________________, MD **Specialty:** ______________

Address: ______________________________ **City:** ______________

State: ______________ **Zip Code:** ______________

Phone #: (   ) ______________ **Fax #: (   )** ______________

Physician Name: ______________________________, MD **Specialty:** ______________

Address: ______________________________ **City:** ______________

State: ______________ **Zip Code:** ______________

Phone #: (   ) ______________ **Fax #: (   )** ______________

Physician Name: ______________________________, MD **Specialty:** ______________

Address: ______________________________ **City:** ______________

State: ______________ **Zip Code:** ______________

Phone #: (   ) ______________ **Fax #: (   )** ______________

Regional Cancer Care Associates, LLC Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access you health information
- Make more informed decisions when authorizing disclosure to others

You're Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by Federal Regulation (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect you health record as provided for the Federal Regulation (45 CFR 164.524)
- Request an amendment to your health record as provided for in Federal Regulation (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

RCCA and our medical staff are a single entity according to Federal Regulation (45 CFR 164.504). With respect to your health record that is created or maintained here we are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to Information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice and for treatment, payment, or health care operations.

For More Information of to Report a Problem

If you have questions and would like additional information, you may contact the Consumer Affairs Department at (201) 996-2010.

If you believe your privacy rights have been violated, you can file a complaint with the Administrative Manager of Consumer Affairs (201) 996-2010, or directly with the Secretary of health and Human Services in Washington (1-877696-6775). There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

We will use you health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will record the actions they took, their observations, and their assessments. In that way, your healthcare team will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged for this facility.

We will use your healthcare information for payment.

For example: A bill may be sent to you or a third-party payer (insurance company). The information on or accompanying the bill may include information that identifies you, as well as you diagnosis, procedures, and supplies used. We may provide copies of the applicable portions of your medical record to your insurance company in order to validate your claim.

We will use your healthcare information for regular health operations.

For example: Healthcare operations, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include: claim preparation for the physician billing in radiology, and certain laboratory tests; a copy service we use when making copies of you medical record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer (insurance company) for services rendered. To protect you health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, or you are a patient on a psychiatric unit, we will release your name, location in the facility to the general visiting public. In addition to this, your religious affiliation will be made available to the visiting clergy.

Notification: We may use or disclose information about your location and general condition to notify or assist in notifying a family member, personal representative, or another person responsible for your care.

Communication with family: Health professionals may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to their involvement in your care or payment.

Research: We may disclose information to researchers when their research has been approved by the Medical Center's Institutional Review Board (IRB). The IRB review the research proposals and established protocols to ensure the privacy for you health information.

Funeral directors and Coroners: We may disclose health information to funeral directors or coroners consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entitles engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Telephone Contact/Appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public authority or attorney, provided that a work force member or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise violated professionals or clinical standards and are potentially endangering one or more patients, workers or the public.

Northern New Jersey Cancer Associates is here to protect our patients and their rights, including respecting the patient's right to privacy and confidentiality. Northern New Jersey Cancer Associates is committed to providing the highest level of care and services to all patients, while adhering to those rights.

Effective Date: April 14, 2003

I, ____, acknowledge receiving the
Patient Name

Regional Cancer Care Associates, LLC. Notice of Privacy Practices.

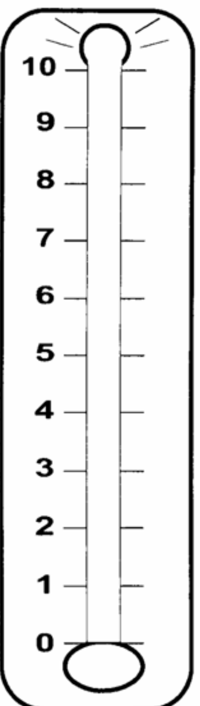
__________________________ *Date*

___________________________ Patient *Signature*

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Other Problems: ______________________

____

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