THE BREAST HEALTH CENTER at PHOENIXVILLE

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, & Zip Code: _____

Contacts: Home Phone: _____ Cell: _____ Work: _____

Email: _____

Female ☐ Male ☐ Marital Status: married ☐ single ☐ divorced ☐ widowed ☐

Employer: _____ Address: _____

Primary Care Physician: _____ Gynecologist: _____

Spouses Name: _____ Employer: _____

Responsible Party Name: _____ Relationship to Patient: _____

Emergency Contact Person & Relationship _____ Phone: _____

Who referred you to our office: _____

Do you have a living will? Yes ☐ No ☐ Would you like information on a living will? Yes ☐ No ☐

Primary Insurance Company _____

ID Number: _____ Group Number _____

Policy Holder Name: _____ Date of Birth of Policy Holder: _____

Relationship to Patient:

Secondary Insurance Company: _____

ID Number: _____ Group Number _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____

I certify the information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to The Breast Health Center at Phoenixville. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: _____ Date: _____

THE BREAST HEALTH CENTER AT PHOENIXVILLE
INITIAL VISIT QUESTIONNAIRE

Name: _____

Medical History (please circle all that apply)

Diabetes	Yes	No	Kidney Disease	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Hepatitis	Yes	No	Back Pain	Yes	No
Heart Attack	Yes	No	Arthritis	Yes	No	Thyroid Disease	Yes	No
Angina	Yes	No	COPD	Yes	No	Anemia	Yes	No
Irregular Heartbeat	Yes	No	Asthma	Yes	No	Osteoporosis	Yes	No
Heart Valve Disease	Yes	No	Sleep Apnea	Yes	No	Depression	Yes	No
High Cholesterol	Yes	No	Blood Clots	Yes	No	Anxiety	Yes	No
Stroke	Yes	No	Blood Transfusion	Yes	No	Other Psychiatric Problems	Yes	No
Seizures	Yes	No	GERD	Yes	No	Alzheimer's Disease	Yes	No
Vascular Disease	Yes	No	Ulcer Disease	Yes	No	Multiple Sclerosis	Yes	No
			Inflammatory Bowel Disease	Yes	No			

Other Medical Problems: please describe

CURRENT MEDICATIONS:

Name:	Dose:	Frequency (for example, twice a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____

PLEASE LIST PREVIOUS SURGICAL PROCEDURES:

Procedure:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Complications from Anesthesia Yes No if yes please describe event_____

_____

_____

ALLERGIES:

Drug:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

PATIENT SOCIAL HISTORY:

Marital Status:	Single ☐	Married ☐	Partnered ☐	Divorced ☐	Widowed ☐				
Alcohol Use:	Never ☐	Rarely ☐	Socially ☐	Daily ☐					
Smoking History:	Never ☐	Previously but quit ☐		Daily Smoker ☐	How many packs per day _____				
Caffeine Intake:	Never ☐	Occasionally ☐		Daily ☐	How many cups per day _____				

Family history of other medical diseases, for example, hypertension, heart disease, diabetes, etc.)

Relative:	Disease
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name: _____

Are you currently suffering from or being treated for any of the following problems: please circle

CONSITUTIONAL SYMPTOMS:

Good General Health.....No Yes
Recent Weight Loss.....No Yes
Recent Weight Gain.....No Yes
Fatigue.....No Yes
Fever.....No Yes

EYES:

Blurry Vision.....No Yes
Double Vision.....No Yes
Glaucoma.....No Yes

EARS, NOSE, MOUTH AND THROAT:

Hearing Loss.....No Yes
Ringing in the Ears.....No Yes
Chronic Sinus Problems.....No Yes
Chronic Nose Bleeds.....No Yes
Voice Change.....No Yes
Swollen Neck Glands.....No Yes

CARDIOVASCULAR:

Chest Pain (Angina).....No Yes
Palpitations..... No Yes
Shortness of Breath with Walking.....No Yes
Shortness of Breath when Lying Flat.....No Yes
Swelling of Legs or Ankles.....No Yes

RESPIRATORY:

Chronic Cough.....No Yes
Shortness of Breath.....No Yes
Asthma.....No Yes
Wheezing.....No Yes
Spitting/Coughing Up Blood.....No Yes

GASTRO-INTESTINAL:

Loss of Appetite.....No Yes
Change in Bowel Movements.....No Yes
Nausea.....No Yes
Vomiting.....No Yes
Frequent Diarrhea.....No Yes
Chronic Constipation..... No Yes
Rectal Bleeding.....No Yes
Abdominal Pain.....No Yes
Heart Burn or GI Reflux (GERD).....No Yes
Ulcer Disease.....No Yes

GENITO-URINARY:

Abnormal PAP Smear.....No Yes
Abnormal Vaginal Discharge or bleeding.....No Yes
Hot Flashes.....No Yes
Kidney Stones.....No Yes
Blood in the Urine.....No Yes

MUSCULO-SKELETAL:

Joint Pain.....No Yes
Joint Swelling.....No Yes
Joint Stiffness.....No Yes
Muscle Weakness.....No Yes
Muscle Cramps.....No Yes
Back Pain.....No Yes
Difficulty Walking.....No Yes

SKIN:

Chronic Rash.....No Yes
Change in Skin Color.....No Yes
Varicose Veins.....No Yes

Neurological:

Chronic Headaches.....No Yes
Dizziness.....No Yes
Numbness or Tingling in Hands or Fingers.....No Yes
Numbness or Tingling in Feet.....No Yes
Tremors.....No Yes
Memory Loss.....No Yes

ENDOCRINE:

Skin Becoming Dryer.....No Yes
Excessive Thirst.....No Yes
Excessive Urination.....No Yes

HEMATOLOGIC/LYMPHATIC:

Anemia.....No Yes
Blood Clots.....No Yes
Unusual Bleeding or Easy Bruising Tendency.....No Yes
Problems with Wound Healing.....No Yes

BREAST

Breast Pain.....No Yes
Nipple Discharge.....No Yes
Breast Swelling.....No Yes
Dimpling of Skin.....No Yes
Nipple Retraction.....No Yes
Breast Lump.....No Yes
Change in Breast Texture.....No Yes
Change in Breast Size.....No Yes

Name: _____

Breast Cancer Risk Assessment Information:

Age: _____ Height: _____ Weight: _____ Bra Size_____

Age of first menstrual cycle _____ Most recent menstrual cycle or your age of last menstrual cycle_____

Age at time of First Delivery _____ Number of Pregnancies _____ Number of Deliveries_____

Did you Breast Feed? Yes ☐ No ☐ If yes, for how long?_____

Do you use Birth Control Pills for contraception? Yes ☐ No ☐

Do you use Depo-Provera for contraception? Yes ☐ No ☐

Do you use the Mirena IUD for contraception? Yes ☐ No ☐

Are you currently Pregnant? Yes ☐ No ☐ If yes, how many weeks?_____

Have you ever used Hormonal Replacement Therapy (HRT) such as Premarin, Prempro, and other drugs? Yes ☐ No ☐

If yes, for how long? _____ If you used HRT in the past, when did you stop? _____

Do you perform regular Breast Self-Exams? Yes ☐ No ☐ If you do, how frequently?_____

Have you had a Hysterectomy? Yes ☐ No ☐

Have you had your Ovaries Removed? Yes ☐ No ☐

Do you get routine Mammograms? Yes ☐ No ☐

Have you ever had a Breast Biopsy? Yes ☐ No ☐ If Yes, which Breast Left ☐ Right ☐ Date_____

If yes, was it a surgical biopsy? Yes ☐ No ☐
If yes, was it a needle biopsy? Yes ☐ No ☐

If you had a breast biopsy, was it because of an abnormal mammogram? Yes ☐ No ☐

If you had a breast biopsy, was it because of a palpable lump? Yes ☐ No ☐

Do you have a personal history of breast cancer? Yes ☐ No ☐ If yes, when where you diagnosed?_____

Family History of Cancer: please record all cancers.

Relative (indicate Maternal or Paternal)	Cancer Type (breast, ovarian, colon, etc.)	Age at diagnosis (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you or a close family relative of Ashkenazi (Eastern European Jewish) Jewish ancestry? Yes ☐ No ☐

Are you interested in genetic testing for breast cancer? Yes ☐ No ☐

THE BREAST HEALTH CENTER at PHOENIXVILLE

Name:_____DOB:_____

Address:_____

Phone_____Cell_____Work_____

Marital Status_____ Spouse's name/DOB:_____

Emergency Contact (other than spouse)_____

Phone:_____Relationship:_____

Financial Policy
Person responsible for finances_____

Who referred you to our Practice_____

Medication History Notice Acknowledgment: I, _____, understand that my Physician may need access to my medication history and may work in conjunction with my pharmacy in order to provide accurate medical treatment.-
_____(patient initials)

COMMUNICATION CONSENT

It is the Policy of **THE BREAST HEALTH CENTER at PHOENIXVILLE** and its staff not to release confidential information to home answering machines, work voice mail or cell phone. When we return your call and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message identifying the residence. Also, information will not be given with any unauthorized person who may answer the phone.

I authorize **THE BREAST HEALTH CENTER at PHOENIXVILLE** and/or its staff to leave medical information pertaining to my care by the following methods, and will assume responsibility to notify them whenever this information changes.

Home telephone (answering machine)	YES	NO	Number_____
Work Phone (voice mail)	YES	NO	Number_____
Cell Phone	YES	NO	Number_____
Fax records for referrals to another Entity?	YES	NO	

If you authorize that information may be released to someone other than yourself, please complete the following:

Name Relationship

_____

_____

_____

Printed Name:_____

Signature:_____DATE:_____