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: ______________________________

Have you received the Covid 19 Vaccination: Yes No
Have you received Covid 19 Booster injection: Yes No

Medical History (please circle all that apply)

Diabetes..........................	Yes	Kidney Disease..............	Yes	Arthritis......................	Yes
Heart Attack..................	Yes	Thyroid Disease............	Yes	Osteoporosis............	Yes
Angina............................	Yes	Hepatitis........................	Yes	Anxiety.......................	Yes
Irregular Heartbeat.......	Yes	Asthma...........................	Yes	Depression................	Yes
Hypertension.................	Yes	COPD..............................	Yes		
High Cholesterol...........	Yes	Blood Clots.....................	Yes		
Stroke.............................	Yes	GERD..............................	Yes		
Anemia...........................	Yes	Sleep Apnea..................	Yes		
Seizures..........................	Yes	Cancer.............................	Yes		

Other Medical Problems: please describe

CURRENT MEDICATIONS:

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

Name: ______________________________

PLEASE LIST PREVIOUS SURGICAL PROCEDURES:

Procedure:	Date:
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________

ALLERGIES:	Drug:	Reaction:
	____________________	______________________________
	____________________	______________________________
	____________________	______________________________
	____________________	______________________________
	____________________	______________________________

SOCIAL HISTORY:

Marital Status:	Single	☐	Married	☐	Partnered	☐	Divorced	☐	Widowed	☐
Alcohol Use:	Never	☐	Rarely	☐	Socially	☐	Daily	☐		
Smoking History:	Never	☐	Ex-Smoker	☐	Daily Smoker	☐	How many packs per day __________			
Caffeine Intake:	Never	☐	Occasionally	☐	Daily	☐	How many cups per day __________			

Name: ______________________________

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

CONSITUTIONAL SYMPTOMS:

- Good General Health........ Yes
- Recent Weight Loss........ Yes
- Fatigue........ Yes
- Fever........ Yes
- Recent Covid-19 infection........ Yes

EYES:

- Double Vision........ Yes
- Blurry Vision........ Yes
- Glaucoma........ Yes

EARS, NOSE, MOUTH AND THROAT:

- Hearing Loss........ Yes
- Ringing in the Ears........ Yes
- Chronic Nose Bleeds........ Yes
- Swollen Neck Glands........ Yes

SKIN:

- Chronic Rash........ Yes
- Change in Skin Color........ Yes
- Dry Skin........ Yes

CARDIOVASCULAR:

- Chest Pain (Angina)........ Yes
- Palpitations........ Yes
- Swelling of Legs or Ankles........ Yes
- Shortness of Breath with Walking........ Yes
- Shortness of Breath when Lying Flat........ Yes

RESPIRATORY:

- Shortness of Breath........ Yes
- Chronic Cough........ Yes
- Asthma........ Yes
- Wheezing........ Yes
- Coughing Up Blood........ Yes

BREAST:

- Breast Lump........ Yes
- Dimpling of Skin........ Yes
- Redness of Breast........ Yes
- Breast Swelling........ Yes
- Breast Pain........ Yes
- Nipple Discharge........ Yes
- Nipple Retraction........ Yes

GENITO-URINARY:

- Abnormal Vaginal Discharge or bleeding........ Yes
- Abnormal PAP Smear........ Yes
- Hot Flashes........ Yes
- Kidney Stones........ Yes
- Blood in the Urine........ Yes

MUSCULO-SKELETAL:

- Joint Pain........ Yes
- Muscle Weakness........ Yes
- Back Pain........ Yes
- Difficulty Walking........ Yes

Neurological:

- Chronic Headaches/Migraines........ Yes
- Dizziness........ Yes
- Numbness or Tingling in Feet........ Yes
- Numbness or Tingling in Hands or Fingers........ Yes
- Memory Loss........ Yes
- Tremors........ Yes

GASTRO-INTESTINAL:

- Loss of Appetite........ Yes
- Nausea........ Yes
- Vomiting........ Yes
- Heart Burn or GI Reflux (GERD)........ Yes
- Abdominal Pain........ Yes
- Frequent Diarrhea........ Yes
- Rectal Bleeding........ Yes

HEMATOLOGIC/LYMPHATIC

- Anemia........ Yes
- Unusual Bleeding or Easy Bruising Tendency........ Yes
- Blood Clots........ Yes
- Problems with Wound Healing........ 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?________________

Are you currently using birth control? No Yes If yes, 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? No Yes If yes, how many weeks?__________

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

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

Do you perform regular Breast Self-Exams? No Yes If yes, how frequently?____________________________

Have you had a Hysterectomy? No Yes If yes, did you have your ovaries Removed? No Yes

Do you get routine Mammograms? No Yes If yes, date of last mammogram______________________

Have you ever had a Breast Biopsy? No Yes 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
If you had a breast biopsy, was it because of a palpable lump? Yes

Do you have a personal history of breast cancer? No. Yes If yes, when you diagnosed?____________ If yes, Stage______________

<u>Family History of Cancer</u>: 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 ☐

Communication Consent

It is the policy of The Breast Health Center at Phoenixville and staff not to release confidential information by home telephone, answering machine, work telephone, voicemail, cell phones. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize The Breast Health Center at Phoenixville and/or their staff to leave medical information

Pertaining to my care by following methods and will assume responsibility to notify them whenever this information changes:

Home telephone (answering machine) Yes No Number ______________________

Work telephone (voicemail) Yes No Number______________________

Cell phone (voicemail) Yes No Number______________________

Fax medical records for referrals to another entity Yes No

If you would like to have information released to someone other than yourself,

Please complete the following:

Name	Relationship	Phone Number

Printed Name: ______________________

Signature: ______________________

Date ______________________