

# REVIEW OF BREAST SYMPTOMS

Please complete this side only

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Age at first period: \_\_\_\_\_ Last Menstrual cycle: \_\_\_\_\_

Age at menopause: \_\_\_\_\_ Hysterectomy date: \_\_\_\_\_ Partial or Complete: \_\_\_\_\_

Oral birth control, type/duration: \_\_\_\_\_

Hormone replacement therapy: type, length of use: \_\_\_\_\_

# Pregnancies: \_\_\_\_\_ # Children: \_\_\_\_\_

Age at first full-term pregnancy: \_\_\_\_\_ Did you breast feed? Yes No Duration: \_\_\_\_\_

Prior breast problems? Yes No explanation: \_\_\_\_\_

Was surgery required? Yes No Type & date: \_\_\_\_\_

Breast reduction? Date: \_\_\_\_\_

Breast augmentation? Date and Type of implant: \_\_\_\_\_

Nipple discharge? Yes No Left Right Both

Color: \_\_\_\_\_ Duration: \_\_\_\_\_ # of episodes: \_\_\_\_\_

Family history of breast cancer: Yes No (include maternal and paternal relatives.)

Who? \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Who? \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Family history of ovarian cancer: Yes No (include maternal and paternal relatives.)

Who? \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Who? \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Additional comments:

**MICHIGAN BREAST SPECIALISTS**  
**PATIENT REGISTRATION INFORMATION FORM**

*Please Print All information*

Referred By: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Maiden: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex: Male Female

Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Marital Status: S M D W

Spouse's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ ext: \_\_\_\_\_

**INSURANCE:**

**Primary:**

Contract #: \_\_\_\_\_ Group#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Relation to You: \_\_\_\_\_

**If insurance Cardholder is different from you or your spouse complete below:**

Cardholder Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Primary:**

Contract #: \_\_\_\_\_ Group#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Relation to You: \_\_\_\_\_

**If insurance Cardholder is different from you or your spouse complete below:**

Cardholder Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Please supply insurance cards so we may copy them for your file.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MICHIGAN BREAST SPECIALISTS PATIENT MEDICAL HISTORY

What is your reason for today's visit? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Has there been any change in this problem? Yes No (circle) \_\_\_\_\_

What? \_\_\_\_\_ How long? \_\_\_\_\_

## Health History

	Yes	No	
Are you in good health?	_____	_____	
Have there been any changes in your general health in the past year?	_____	_____	
Have you had an operation or been hospitalized in the past 5 years?	_____	_____	
Do you smoke?	_____	_____	how much/day _____
Do you drink alcohol?	_____	_____	how much/day _____

## Have you had or do you currently have:

	Yes	No		Yes	No
Heart trouble (mitral valve prolapse)	_____	_____	Constipation	_____	_____
Heart Attack	_____	_____	Liver disease or jaundice	_____	_____
Chest Pain, angina	_____	_____	Hepatitis	_____	_____
Heart Surgery/Bypass/Stents	_____	_____	Stomach ulcers/GERD	_____	_____
Cardiac Pacemaker	_____	_____	Gallbladder disease Kidney trouble	_____	_____
Heart murmur / Arrythmia	_____	_____	Epilepsy/seizures	_____	_____
Rheumatic Fever	_____	_____	Delay in healing	_____	_____
Vascular Surgery	_____	_____	Chronic fatigue/night sweats	_____	_____
Stroke	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Artificial Joints	_____	_____
Difficulty breathing	_____	_____	Placed when? _____		
Asthma	_____	_____	Arthritis/rheumatism	_____	_____
Hay fever/sinus problems	_____	_____	Glaucoma/eye disease	_____	_____
Emphysema/COPD	_____	_____	Thyroid trouble	_____	_____
Bronchitis/chronic cough	_____	_____	Mental Health issues	_____	_____
Tuberculosis	_____	_____	History of alcohol abuse	_____	_____
Anemia	_____	_____	History of drug abuse	_____	_____
Leukemia	_____	_____	Surgery	_____	_____
Cancer	_____	_____	Type and date: _____		
Type: _____			_____		
Radiation/chemotherapy	_____	_____	_____		

## Family History: is there a family history of:

	Yes	No	Relation to you
Anesthetic problem	_____	_____	_____
Bleeding disorders	_____	_____	_____
Diabetes	_____	_____	_____
Heart disease	_____	_____	_____
Kidney disease	_____	_____	_____
Systemic Lupus	_____	_____	_____
Cancer of:			
breast	_____	_____	_____
colon	_____	_____	_____
ovaries or prostate thyroid	_____	_____	_____
other	_____	_____	_____

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**Medications:**

**Please list all medications and herbal/vitamin supplements with dosage that you take daily :**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

**Allergies: Are you allergic to, or have you ever had a reaction to the following?**

	Yes	No	Reaction		Yes	No	Reaction
Penicillin	___	___	_____	Aspirin	___	___	_____
Antibiotics	___	___	_____	Sulfa Drugs	___	___	_____
Acetaminophen (Tylenol)	___	___	_____	Codeine	___	___	_____
Sedatives	___	___	_____	Other medicine	___	___	_____
Food Allergies	___	___	_____	Latex	___	___	_____
Other food or drug : _____				Iodine	___	___	_____
				CT Scan contrast	___	___	_____

**Anesthesia**

	Yes	No	Notes
Have you ever had general anesthesia?	___	___	_____
Have you ever had a reaction to general or local anesthesia?	___	___	_____

Patient Signature : \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or guardian, if patient is a minor)

Reviewed with patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Breast Care Patient History

Please answer each question. A patient's race, ethnic background, or education level are examples of factors that have been shown to make a difference in breast care treatment and outcome.

### Spanish/Hispanic Origin:

- Spanish/Hispanic  
 Non-Spanish
- Unknown

### Racial Background:

- Caucasian  
 African American  
 American Indian, Aleutian, Eskimo
- Asian or Pacific Islander  
 Other

### Current Employment Status:

- Employed 32 hrs/wk or more  
 Employed less than 32 hrs/wk  
 Full time student  
 Part time student  
 < 32 hrs/wk & part time student  
 Homemaker
- On medical leave  
 Disabled  
 Retired  
 Unemployed, seeking work  
 Other  
 Unknown

### Level of Physical Activity:

- Fully active, no restrictions  
 Restricted strenuous activity  
 Up more than 1/2 a day
- Spends >1/2 day in bed/chair  
 Unable to care for self, all day in bed/chair  
 Unknown

### Educational Status:

- Some grade school  
 Some high school  
 High school graduate  
 Vocational/Technical School  
 Some college/Associates Degree
- College  
 Graduate School (MA, MS, PhD, MD, etc)  
 Other  
 Unknown

### Have you had a menstrual period in the past six months?

- Yes, natural periods/ birth control  
 Yes, on hormone replacement
- No  
 Unknown

### If no menstrual period in the last 6 months" why did they stop?

- Unknown reason  
 Pregnancy or breast feeding  
 Chemo, radiation or hormone tx  
 Hormone replacement  
 Natural menopause  
 Medical condition, ovarian failure
- Hysterectomy w/ovaries left  
 Hysterectomy/both ovaries removed  
 Hysterectomy/unknown if ovaries removed  
 Ovaries removed/no hysterectomy  
 Other, specify \_\_\_\_\_

\* if applicable: date of bilateral oophorectomy (ovaries removed): \_\_\_ / \_\_\_ / \_\_\_

### Age when menopause occurred:

- Not applicable  
 Age unknown  
 <40  
 40-44
- 45-49  
 50-54  
 >54

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:  
Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of its Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my protected health information is used or disclosed to carry out treatment, payment or health operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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# Michigan Breast Specialists

## PATIENT HIPAA AUTHORIZATION

I hereby authorize you to disclose the specific information only for the purposes of my care and treatment to the parties I authorize below which include; insurance company(s) for treatment and payment; other physicians involved in my care and treatment; and family members that I authorize to receive my medical information.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication be made by alternative means.

Please list the physicians and family members that your protected health information (PHI) may be released to:

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This authorization shall remain in effect from the date signed below until December 31, 2010.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office in writing, attn: Paula Labadie, Privacy Officer at 19229 Mack Avenue, Suite 38, Grosse Pointe Woods, MI, 48236.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Patient/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

You have a right to have a copy of this form after you sign it.  
Office Use Only

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**I wish to be contacted in the following manner regarding test results, scheduling surgical procedures and appointments, etc. (check all that apply):**

Home Telephone

- Leave message on answering machine
- Leave message with a family member
- Leave message with call-back number only

- Cellular Phone \_\_\_\_\_
- Other \_\_\_\_\_

Work Telephone

- Leave message with detailed information
- Leave message with call-back number only

Written Communication

- Mail to home address
- Mail to work address
- Fax to this number \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_