# Breast Clinic New Patient Paperwork

| DEMOGRAPHIC INFORMATION | |
|---|---|
| **Patient Name:** | **DOB:** |
| **Referring provider:** | **Primary Care Provider:** |
| **OB/GYN Provider:** | **Other Provider:** |
| **Marital Status:** ☐ Single ☐ Married ☐Widowed ☐ Divorced | **Who lives with you?** |
| **Do you live in (check one)** ☐ House ☐ Apartment ☐ Assisted Living ☐ Nursing Home ☐ _____ | |
| **Next of Kin/Emergency Contact:** | |
| **Address:** | **Phone number:** |

| | | | | |
|---|---|---|---|---|
| **Ethnic Background** | ☐ Caucasian | ☐ African American | ☐ Pacific Islander | ☐ Asian |
| | ☐ Hispanic | ☐ Ashkenazi Jewish | ☐ Other: | |

**Known Allergies (Medication/Food/Environmental) and reaction:** ☐ No Allergies

| REASON FOR TODAY'S VISIT | | | | |
|---|---|---|---|---|
| | | | **Date noticed** | **Describe** |
| ☐ New Breast Lump / Mass | ☐ RIGHT | ☐ LEFT | | |
| ☐ Breast Pain | ☐ RIGHT | ☐ LEFT | | |
| ☐ Breast Skin Change | ☐ RIGHT | ☐ LEFT | | |
| ☐ Nipple Discharge | ☐ RIGHT | ☐ LEFT | | |
| ☐ Abnormal Biopsy | ☐ RIGHT | ☐ LEFT | | |
| ☐ Abnormal Breast Imaging | ☐ RIGHT | ☐ LEFT | | |
| ☐ New Diagnosis of Breast Cancer | ☐ RIGHT | ☐ LEFT | | |
| ☐ High Risk Monitoring | | | | |

| BREAST DIAGNOSTIC TESTING COMPLETED | | | |
|---|---|---|---|
| **Date of last mammogram:** | | **Where?** | **Result:** |
| **Date of last breast ultrasound:** | | **Where?** | **Result:** |
| **Date of last breast MRI:** | | **Where?** | **Result:** |
| **Other exam?** | | **Where?** | **Result:** |

| BREAST HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| | | | | | Describe |
| Do you have breast implants? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |
| Have you had breast surgery? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |
| Previous diagnosis of breast cancer? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |
| Do you have atypical ductal hyperplasia (ADH)? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |
| Do you have atypical lobular hyperplasia (ALH)? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |
| Do you have lobular carcinoma in-situ (LCIS)? | ☐ YES | ☐ NO | ☐ RIGHT | ☐ LEFT | |

| GYNECOLOGICAL HISTORY | |
|---|---|
| Age menstrual cycle (period) started: | Do you still have a period? ☐ YES ☐ NO |
| Age at first birth: | Number of pregnancies: |
| Number of live births: | Number of miscarriages: |
| Any miscarriages after 12 weeks? ☐ YES ☐ NO | Number of abortions: |
| Did you breast feed? ☐ YES ☐ NO | Did you ever use infertility treatments? ☐ YES ☐ NO |
| Gone through menopause? ☐ YES ☐ NO | If you have gone through menopause, when? |
| Have you had a hysterectomy? ☐ YES ☐ NO | Ovaries removed? ☐ YES ☐ NO |
| Did you use oral birth control pills? ☐ YES ☐ NO | Used hormone therapy? ☐ YES ☐ NO |
| Do you currently use hormone therapy? ☐ YES ☐ NO | Have you ever used DES? ☐ YES ☐ NO |

| PAST SURGICAL HISTORY |
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| Type and Date of surgeries: |
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| Any implanted devices (pacemaker, pumps, etc.)? ☐ YES ☐ NO Describe: |

| PERSONAL HISTORY OF CANCER | | | |
|---|---|---|---|
| Breast ☐ YES ☐ NO | Ovarian ☐ YES ☐ NO | Uterine ☐ YES ☐ NO | Cervical ☐ YES ☐ NO |
| Thyroid ☐ YES ☐ NO | Colon ☐ YES ☐ NO | Other: | |

| SOCIAL HISTORY | | | | |
|---|---|---|---|---|
| **Tobacco** | ☐ **YES** ☐ **NO** | **Packs per day:** | **Number of Years:** | **Year Quit:** |
| **Alcohol** | ☐ **YES** ☐ **NO** | **Amount daily:** | **Amount weekly:** | **Year Quit:** |
| **Recreational Drugs** | ☐ **YES** ☐ **NO** | **Type:** | **Amount:** | **Year Quit:** |

| MEDICAL HISTORY |
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| **Please list any medical conditions for which you have been treated:** |
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| **MEDICATIONS** |
| **Please list any prescription, over the counter, supplements or herbal medications:** |
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| PHARMACY | |
|---|---|
| **Preferred Pharmacy:** | **Phone Number:** |
| **Pharmacy:** | **Phone Number:** |

| FAMILY HISTORY OF CANCERS | | | |
|---|---|---|---|
| **Type of Cancer** | **Parents, Brothers, Sisters, & Children** | **Mother's side: Aunts, Uncles, Cousins, Grandparents** | **Father's Side: Aunts, Uncles, Cousins, Grandparents** |
| ***** PLEASE INCLUDE AGE AT WHICH FAMILY MEMBER WAS DIAGNOSED WITH THEIR CANCER ***** | | | |
| **Breast** | | | |
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| **Endometrial / Uterine** | | | |
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| **Ovarian** | | | |
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| **Colon** | | | |
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| **Pancreatic** | | | |
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| **Prostate** | | | |
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| **Other** | | | |
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**REVIEW OF SYSTEMS**

**Have you experienced any of the following problems are a regular basis?**

| YES | NO | GENERAL |
|---|---|---|
| | | Weight Loss / Gain |
| | | Fevers |
| | | Chills |
| | | Appetite Changes |
| | | Sexual Dysfunction |
| | | Skin Rashes |
| | | **HEAD AND NECK** |
| | | Neck Swelling |
| | | Neck Stiffness |
| | | Hoarseness |
| | | Hearing Loss |
| | | **RESPIRATORY** |
| | | Cough |
| | | Wheezing |
| | | Shortness of breath |
| | | **GASTROINTESTINAL** |
| | | Nausea/vomiting |
| | | Abdominal pain/bloating |
| | | Appetite Changes |
| | | Diarrhea |
| | | Constipation |
| | | Bleeding |
| | | Black or bloody stools |
| | | Have you ever had a colonoscopy?<br>When? _____ |
| | | **CARDIAC / HEART** |
| | | Chest Pain |
| | | Chest Pressure |
| | | Palpitations |
| | | **HEAD & NECK** |
| | | Neck Swelling |
| | | Neck Stiffness |
| | | Hoarseness |
| | | Throat pain/Voice changes |
| | | Hearing Loss |
| | | Eye problems |
| | | Have you had a dental exam? |

| YES | NO | NEUROLOGIC |
|---|---|---|
| | | Seizures |
| | | Headache |
| | | Numbness or tingling |
| | | Weakness |
| | | **LYMPH NODES** |
| | | Enlarged Lymph Nodes |
| | | **MUSCULOSKELETAL** |
| | | Back Pain |
| | | Neck Pain |
| | | Leg Pain |
| | | Arm pain |
| | | Joint pain |
| | | Leg swelling |
| | | Have you had a bone density test?<br>When? _____ |
| | | **URINARY** |
| | | Bloody or brown urine |
| | | Painful urination |
| | | Frequent urination or difficulty holding |
| | | **EXPOSURE TO POSSIBLE ILLNESS** |
| | | Contact with sick person |
| | | Recent Travel |
| | | **PSYCHOLOGICAL / MENTAL HEALTH** |
| | | Depression |
| | | Changes in sleep patterns |
| | | Changes in memory |
| | | Anxiety |
| | | **HEMATOLOGIC / BLOOD** |
| | | Bruising |
| | | Bleeding |
| | | Have you ever had a blood clot? |
| | | Have you ever had a blood transfusion? |
| | | Nosebleeds? |

## NOTIFICATION REGARDING PAPERWORK COMPLETION

**Surgical Patients** – Please submit any paperwork required for time off work due to surgery to the breast surgeons' office. This paperwork may be faxed to the office at 513-865-5112. **Please allow 10 business days for completion.**

**Breast Cancer Patients** - Due to the different treatment methods used to treat breast cancer, paperwork (FMLA request, short-term disability, etc.) may need to be submitted to each of your of providers. Please direct any paperwork related to surgery to the breast surgeon's office or nurse navigator. If medical therapy such as chemotherapy requires you to be away from work, please submit your request to the medical oncology office. If radiation therapy requires you to be away from work, please submit your request to the radiation oncology office. Ensure you have completely filled out your portion of the paperwork including the patient's name and date of birth. **Please allow 10 business days for completion.**

## NOTIFICATION REGARDING PRESCRIPTION REFILLS

Please **allow two business days** to prepare medication refill requests.

**I acknowledge I have read and understand the above process regarding completion of patient paperwork and refill requests.**

**Patient Signature: _____ Date:_____**