THE BREAST CLINIC

First__________________ Middle______ Last Name__________________
Maiden Name or Name Changes __________________
Date of Birth ___/___/_____ Marital Status _______
Email Address __________________@_________
Mailing Address _________________ City _________ State ___ Zip Code ______
Home Phone (_____)-_____-________ Cell Phone (_____)-_____-________
Occupation ______________________ Company ______________________
Work Phone (_____)-_____-________

Primary Care Doctor ______________________
OB/Gyn Doctor______________________
Other Doctor ______________________
Preferred Pharmacy and Location ______________________
□ **Yes**, I authorize The Breast Clinic to electronically obtain my medication history for the pharmacy listed above.

If your insurance information has changed, please advise us so that we can update and correct your information.

If your insurance is through your spouse, please fill in the:
Full Name ______________Date of Birth ___/___/___
Social Security Number____-____-_____

Regarding Mammogram Results:
Please select one of the following ways you want to receive your results:
□ email address ________________@_________
□ personal fax (_____)-_____-________
□ mailing address

Please, be sure to create your account at http://www.thebreastclinicfwb.com/
Taking just a few minutes to Register will give you access to valuable information and services provided in a secure and confidential manner. Should you have any problems, please contact us.

I CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XIX OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OF ITS INTERMEDIARIES OR CARRIER ANY INFORMATION NEEDED FOR THIS OR RELATED INSURANCE CLAIMS. I REQUEST THAT THE PAYMENT OF AUTHORIZE BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR INSURANCE CLAIM PROCESSING. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS OF THE BREAST CLINIC.

RESPONSIBLE PARTY SIGNATURE ____ DATE __________

PLEASE CONTINUTE TO THE NEXT PAGE

What is the reason for today's visit? Are you having any problems that you want to discuss today?

Please tell us about any health changes: surgeries, hospitalizations or pregnancies in the past year:

Has there been a change in your family history of breast or ovarian cancer in the last year?
Y_____ N_____
IF YES: BREAST CANCER or OVARIAN CANCER? ____________
MOTHER'S or FATHER'S SIDE? ________ THEIR RELATIONSHIP TO YOU? __________

Since you were last here, have you been diagnosed with any kind of Cancer? Y_____ N_____
IF YES: What Kind? ____________________ Who diagnosed you? __________________
Have you had any chemotherapy or radiation treatments? Y_____ N_____

What was the date of last menstrual period? _________ **Last PAP Smear?** ___________

Are you…
a) Having Menopausal Symptoms? _____ b) Hot Flashes? _____ c) Night Sweats? _____
d) Emotional ups & downs? _____ e) Vaginal Dryness? _____ f) Loss of interest in sex? _____
g) Pain with sex? _____ h) Loss of sleep? _____

Have you had Breast Implants since you were last seen here? Y____ N____
IF YES: Silicone or Saline? _________ Placed under muscle? _____ Date of Surgery __________

Are you taking any hormones? (Estrogens, Progesterones, DHEA, etc.) Y________ N________

How often do you…
a) Drink Alcohol? ______________ How many servings weekly? ______________
b) Drink Caffeine? ______________ How many servings daily? ______________
c) Use Tobacco? ______________ How much do you smoke? ______________
How long have you smoked? ______________
d) Exercise? ______________ What kind? ______________
How long? ______________ How often? ______________

Have you..
a) Gained or Lost weight in the past year? If so, was it intentional? ______________
b) Any special diet? : ______________

When was your last:
a) Bone Density _________ b) Colonoscopy _________ c) Full Physical _________
d) Chest X Ray _________ e) EKG _________

Please list any <u>allergies</u> to medication that have developed in the past year:

Please look over attached medication and allergy list; mark off any medication you are no longer taking, add any medication and strength that may not be on the list.