Georgia Breast Care

BREAST & MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____/_____/_____ **REFERRING PHYSICIAN:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP :** _____ **PHONE:** _____

DATE OF LAST CLINICAL/PHYSICAL BREAST EXAM: _____ **HEIGHT:** _____ **WEIGHT:** _____ **BRA SIZE:** _____

REASON FOR VISIT

Abnormal Mammogram:	□ yes □ no	□ Right □ Left	Duration of complaint: _____
Lump:	□ yes □ no	□ Right □ Left	Duration of complaint: _____
Pain:	□ yes □ no	□ Right □ Left	Duration of complaint: _____
Nipple Discharge:	□ yes □ no	□ Right □ Left	Duration of complaint: _____
Change in Breast Appearance:	□ yes □ no	□ Right □ Left	Duration of complaint: _____
Second Opinion:	□ yes □ no	□ Right □ Left	Duration of complaint: _____

BREAST IMAGING

Mammogram: □ yes □ no	**Ultrasound:** □ yes □ no	**MRI :** □ yes □ no
Date: _____	**Date:** _____	**Date:** _____
Facility: _____	**Facility:** _____	**Facility:** _____

PRIOR BREAST SURGERY *(if applicable)*

Breast implants : □ yes □ no **Reduction:** □ yes □ no

Biopsy: □ yes □ no **If yes,** □ right □ left **Type:** □ needle □ surgical **History of atypia:** □ yes □ no

BREAST CANCER TREATMENT *(if applicable)*

Lumpectomy: □ yes □ no □ Right □ Left

Radiation: □ yes □ no Date: _____

Mastectomy: □ yes □ no □ Right □ Left **Reconstruction:** □ Right □ Left

Chemotherapy: □ yes □ no Date: _____

GENETIC TESTING *(if applicable)*

Genetic testing: □ yes □ no

If yes, Where: _____ Date: _____ Results: _____

Has any member of your family had genetic testing: □ yes □ no

If yes, Where: _____ Date: _____ Results: _____

MEDICATIONS

☐ *CHECK HERE IF* **NONE** ***include:*** ***over-the-counter medicines, vitamins, herbals and supplements***

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

☐ **I take aspirin or blood thinners.**

Please specify type & dosage : _____

☐ **I take a steroid.**

Please specify type & dosage: _____

Should you require additional space for medication list, **please check here** ☐ ***and write on the back of this page.***

ALLERGIES

☐ *CHECK HERE IF* **NONE**

☐ **MEDICATIONS** _____

☐ **LATEX** ☐ **LIDOCAINE** ☐ **IODINE CONTRAST MATERIAL** ☐ **MRI CONTRAST** ☐ **ADHESIVE TAPE**

☐ **OTHER:** _____

PAST SURGERIES

☐ *CHECK HERE IF* **NONE**

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

PAST MEDICAL HISTORY

*Please **MARK** all that apply.*

BLOOD/ONCOLOGY: ☐ Anemia ☐ Bleeding/Clotting Disorder ☐ Blood Clot ☐ HIV/AIDS ☐ Cancer: type _____

CARDIAC: ☐ High Blood Pressure ☐ Heart Failure ☐ Stents ☐ Heart Bypass ☐ Atrial Fibrillation ☐ Pacemaker/Defibrillator ☐ Heart Attack ☐ Arrhythmia ☐ Heart Murmur

URINARY: ☐ Frequent urinary tract infections ☐ Kidney Stones ☐Dialysis: Days _____ ☐ Kidney Disease: _____

RESPIRATORY: ☐Asthma ☐Tuberculosis/Positive TB test ☐ Emphysema/COPD ☐ Pulmonary Embolism ☐ Sleep Apnea

AUTOIMMUNE: ☐ Lupus ☐ Other: _____

NERVOUS: ☐ Headaches ☐ Anxiety/Depression ☐ Stroke ☐ Seizure

MUSCULOSKELETAL: ☐ Fibromyalgia ☐ Arthritis ☐ Joint Replacement

GASTROINTESTINAL: ☐ Hepatitis B or C ☐ Ulcer ☐ Acid Reflux Disease ☐ GI bleeding ☐ Diverticulitis

ENDOCRINE: ☐ Diabetes ☐ Thyroid Disorder **EYES/EARS/NOSE:** ☐ Glaucoma ☐ Hearing Loss ☐ Vision Problems

REVIEW OF SYSTEMS

*Please **MARK** all that apply.*

CONSTITUTIONAL: ☐ Weight Gain ☐ Weight Loss ☐ Fevers ☐ Sweats

ENDOCRINOLOGY: ☐ Heat/Cold Intolerance ☐ Excessive thirst/urination

NEUROLOGY: ☐ Weakness ☐ Dizziness ☐ Gait problems ☐ Memory problems ☐ Use a cane, walker, or wheelchair

EARS/NOSE: ☐ Vertigo ☐ Hearing Aid

EYES: ☐ Glasses/Contacts

RESPIRATORY: ☐ Cough ☐ Wheezing ☐ Shortness of Breath

HEMATOLOGY/LYMPHATIC: ☐ Bruise easily ☐ Enlarged glands

SKIN: ☐ Rashes ☐ Sores ☐ Itching

GENITOURINARY: ☐ Burning/Painful Urination ☐ Blood in Urine

CARDIOVASCULAR: □ Chest pain/angina □ Palpitations □ Leg swelling

GASTROINTESTIONAL: □ Loss of appetite □ Heartburn □ Rectal Bleeding/Blood in Stool

MOUTH/THROAT: □ Dentures □ Bleeding gums □ Voice Change

MUSCULOSKELETAL: □ Joint/Back pain □ Muscle aches □ Stiffness □ Swelling

SOCIAL HISTORY

Tobacco use: □ yes □ no

Packs/Day: _____ **Years:**

Former Smoker: □ yes □ no **Year quit** _____

Alcohol use: □ yes □ no

□ **Daily** □ **Weekly** □ **Occasionally**

Quantity: _____

Caffeine: □ yes □ no

Cups/per day _____

□ **Coffee** □ **Tea** □ **Soda** □ **Chocolate**

GYNECOLOGICAL/OB HISTORY

Menstrual History: Age at onset: ____ Age at Menopause: ____ Age of Last Menstrual Period: ___ Age at Hysterectomy: _____

First day of Last Menstrual Period: _____/_____/_____

Gynecological History: □ Uterus removed □ One Ovary removed □ Both Ovaries removed

Hormonal Therapy: Birth Control : _____ □ Fertility Treatment: _____

Hormone Replacement Therapy: □ Current □ Never □ Used in the past: How long? _____ When quit? _____ Type: _____

Childbirth History: # of Pregnancies: _____ # of Children: _____ Age at 1st Childbirth: _____ Breastfeed**:** □ yes □ no

History of Breast Biopsy: □ yes □ no ***If yes:*** □ right □ left □ needle core biopsy □ surgical biopsy Date: _____

MALE PATIENTS

Testicular mass: □ yes □ no

Recent testicular exam by a physician: □ yes □ no

FAMILY HISTORY

Family History of Breast Cancer: □ yes □ no

If yes*, please list family member & their age at diagnosis:* _____

_____

Family History of Colon, Ovarian, Pancreatic, Prostate Cancer or Melanoma? □ yes □ no

If yes*, please list family member & their age at diagnosis:* _____

_____

Ashkenazi Jewish or Eastern European Ancestry: □ yes □ no

PHARMACY

Pharmacy Name: _____ **Address:**_____

Phone: _____

I authorize Georgia Breast Care, PC and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Georgia Breast Care, PC. It may include prescriptions from the past several years.

My signature below certifies that I have read and understand the scope of my consent and I authorize access.

CONSENT & RELEASE

This consent covers all the medical services rendered to me by the providers at Georgia Breast Care, PC. Patient or legal custodian of those individuals that are under the age of 18 authorizes the Staff Physician(s), Nurse Practitioner, or Physician Assistant to examine and treat the above patient. The duration of this consent is indefinite and will continue until revoked. I understand I may revoke this consent by informing the practice in writing. If I do revoke this consent, it will not affect anything done prior to the date the revocation is received.

CONSENT FOR TREATMENT: I have voluntarily presented to Georgia Breast Care, PC for consent to treatment of me by the practice and its staff, including its physicians, physician assistants, nurse practitioners, and other employees, providers, and staff members. Care may include; but, it is not limited to: general treatment, use of prescribed medications, performance of diagnostic procedures, test and cultures, and performance of other laboratory tests that my physician or his/her designee determines medically necessary or advisable based upon my treatments or examinations and I understand that all medical treatments contain inherent risks. I understand that my consent is voluntary, if I refuse to sign this consent, the practice may refuse to treat me except in a case of emergency.

CONSENT FOR HEALTH INFORMATION EXCHANGE: I hereby acknowledge and consent that Georgia Breast Care will share my medical information, as permitted under federal law (HIPAA) and Georgia State Law, with my healthcare providers through a health information exchange.

CONSENT FOR PHOTOGRAPHY: I consent to have my image taken by the practice and understand that my photographs, digital, and other images will become part of my medical record and therefore protected, used and/or disclosed in accordance with practice's Notice of Privacy Practices. I understand that the practice will own these images. In addition, to ensure your confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices.

☐ Please initial here if you ***decline*** to have your photograph taken for identification in your electronic medical record.

The undersigned patient or authorized individual acting on behalf of the patient, understands and agrees as follows:

_____ _____

PATIENT SIGNATURE or AUTHORIZED SIGNATURE **DATE**