



BREAST & MEDICAL HISTORY

PATIENT NAME: _____ DOB: ____/____/____ PRIMARY CARE MD: _____

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

DATE OF LAST CLINICAL/PHYSICAL BREAST EXAM: _____ OB/GYN MD: _____ REFERRED BY: _____

HEIGHT: _____ WEIGHT: _____ ETHNICITY: Hispanic/Latin Not Hispanic/Latin RACE: African-American Asian
 Hispanic American Indian or Alaska Native Native Hawaiian or Pacific Islander White Other: _____

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: _____

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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

GASTROINTESTINAL: 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: _____

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: _____

FAMILY HISTORY

Family History of Breast Cancer: yes no

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

Family History of Colon, Ovarian, 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

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