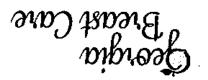
BREAST & MEDICAL YOUNG



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			MEDICATIONS		
	· CHECK HERE IF NONE	<u>include</u> :	over-the-counter med	icines, vitamins, herbals an	d supplements
Name: _			Dosage	:	
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MEDICA	TIONS		CHECK HERE IF NONE		
				LANG CONTRACT	
	· LIDOCAINE				- ADHESIVE TAPE
			2	PATIENT NAME:	

PAST SURGERIES	
CHECK HERE IF NONE	
SURGERY:	DATE:
PAST MEDICAL HISTORY	
Please <u>MARK</u> all that opply.	
BLOOD/ONCOLOGY: • Anemia • Bleeding/Clotting Disorder • Blood Clot	HIV/AIDS - Cancer: type
CARDIAC: • High Blood Pressure • Heart Failure • Stents • Heart Bypass • At	trial Fibrillation • Pacemaker/Defibrillator
Heart Attack	
URINARY: • Frequent urinary tract infections • Kidney Stones • Dialysis: Days _	• Kidney Diseose:
RESPIRATORY: • Asthma • Tuberculosis/Positive TB test • Emphysema/COPD	Pulmonary Embolism
AUTOIMMUNE: • Lupus • Other:	
NERVOUS: • Headaches • Anxiety/Depression • Stroke • Seizure	
MUSCULOSKELETAL: • Fibromyalgia • Arthritis • Joint Replacement	
GASTROINTESTINAL: • Hepatitis B or C • Ulcer • Acid Reflux Disease • 0	SI bleeding • Diverticulitis
ENDOCRINE: • Diabetes • Thyroid Disorder EYES/EARS/NOSE: • Glau	coma • Hearing Loss • Vision Problems
REVIEW OF SYSTEMS	
Please <u>MARK</u> all that apply.	
CONSTITUTIONAL: • Weight Gain • Weight Loss • Fevers	• Sweats
ENDOCRINOLOGY: • Heat/Cold Intolerance • Excessive thirst/urination	
NEUROLOGY: • Weakness • Dizziness • Gait problems • Memory pr	roblems • Use a cane, walker, or wheelchair
EARS/NOSE: • Vertigo • Hearing Aid	
EYES: • Glasses/Contacts	
RESPIRATORY: • Cough • Wheezing • Shortness of Breath	
RESPIRATORY: • Cough • Wheezing • Shortness of Breath HEMATOLOGY/LYMPHATIC: • Bruise easily • Enlarged glands SKIN: • Rashes • Sores • Itching	

3

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 Caffeine: • yes • no Caffeine: • yes • no					
Packs/Day: Years: • Daily • Weekly • Occasionally Cups/per day					
Former Smoker: • yes • no Year quit Quantity: • 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 1 st Childbirth: Breastfeed: • yes • no					
History of Breast Biopsy: • yes • no If yes: • right • left • needle core biopsy • surgical biopsy Date:					
MALE PATIENTS					
esticular mass: • yes • no					
lecent testicular exam by a physician: • yes • no					
FAMILY HISTORY					
amily History of Breast Cancer: • yes • no					
yes, please list family member & their age at diagnosis:					
amily History of Colon, Ovarian, Pancreatic, Prostate Cancer or Melanoma? • yes • no					
yes, please list family member & their age at diagnosis:					
shkenazi Jewish or Eastern European Ancestry: • yes • no					

PATIENT NAME: _

PHARMACY	
Pharmacy Name: Address:	
Phone:	
I authorize Georgia Breast Care, PC and its affiliated providers to view my external prescription histo	yy via the RxHub service.
I understand that prescription history from multiple other unaffiliated medical providers, insurance of benefit managers may be viewable by my providers and staff at Georgia Breast Care, PC. It may in the past several years.	ompanies, and pharmacy nclude prescriptions from
My signature below certifies that I have read and understand the scope of my consent and I author	ize access.
CONSENT & RELEASE	
This consent covers all the medical services rendered to me by the providers at Georgia Breast Caracustodian of those individuals that are under the age of 18 authorizes the Staff Physician(s), Nurse Prassistant to examine and treat the above patient. The duration of this consent is indefinite and will conderstand I may revoke this consent by informing the practice in writing. If I do revoke this consent done prior to the date the revocation is received.	ractitioner, or Physician Continue until revoked. 1
CONSENT FOR TREATMENT: I have voluntarily presented to Georgia Breast Care, PC for co by the practice and its staff, including its physicians, physician assistants, nurse practitions providers, and staff members. Care may include; but, it is not limited to: general treatmemedications, performance of diagnostia procedures, test and cultures, and performance that my physician or his/her designee determines medically necessary or advisable based examinations and I understand that all medical treatments contain inherent risks. Lunders voluntary, if I refuse to sign this consent, the practice may refuse to treat me except in a containt.	ers, and other employees, ent, use of prescribed of other laboratory tests dupon my treatments or stand that my consent is
CONSENT FOR HEALTH INFORMATION EXCHANGE: I hereby acknowledge and consent the share my medical information, as permitted under federal law (HIPAA) and Georgia State healthcare providers through a health information exchange.	at Georgia Breast Care wil ELaw, with my
CONSENT FOR PHOTOGRAPHY : I consent to have my image taken by the practice and uphotographs, digital, and other images will become part of my medical record and there and/or disclosed in accordance with practice's Notice of Privacy Practices. I understant these images. In addition, to ensure your confidentiality and privacy, any type of electroprohibited at any location within these offices.	efore protected, used that the practice will own
Please initial here if you decline to have your photograph taken for identification medical record.	ication in your electronic
the undersigned patient or authorized individual acting on behalf of the patient, understands and a	grees as follows:
PATIENT SIGNATURE or AUTHORIZED SIGNATURE	DATE