Preparing For Your Appointment with Dr. Holmes

To make the most of your appointment with Dr. Holmes, it is helpful that you come fully prepared. Please use the following checklist includes to see how you should prepare for your appointment. If you are unable to obtain the some of the information listed below, please let us know and we will help you obtain them. Download a copy of the checklist.

QUESTIONS: Prepare your list of questions before your appointment and bring them with you to make sure that you do not forget to ask about specific things you want to know.

COMPANION: Bring A Family Member or Friend to provide emotional support, an extra pair of ears, and an aid to help you write down things that you learn during your appointment.

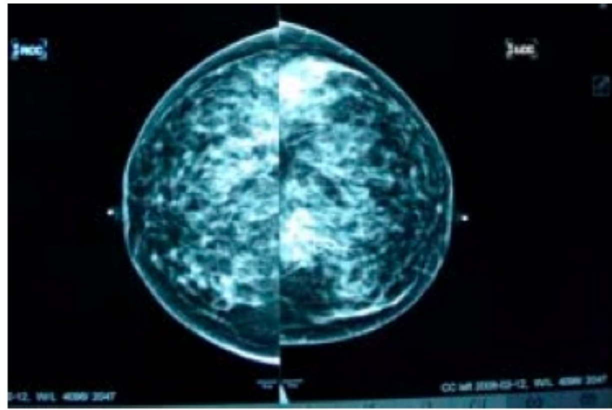
FAMILY HISTORY: Learn about your family history of cancer. The history of cancer **among female and male relatives and their age of diagnosis** might influence the advice that you receive. Ask your parents and/or siblings if they know of any cancers among immediate or distant blood relatives that you might not be aware. Write them down, including the approximate age of diagnosis, and bring the list with you. Please use the attached form to record the information.

LIST OF YOUR DOCTORS: Please bring a list of the names, addresses, and phone numbers of all of the doctors who care for you so that Dr. Holmes can discuss your care with them and provide them a copy of his records. Please include the contact information for your primary care doctor, gynecologist, internist, family practitioners, surgeons, etc. Please provide their complete name (first and last), office mailing address (including suite #), office phone and fax numbers, and email addresses if you can get them. Please use the attached form to record the information.

GENERAL QUESTIONNAIRE: To make your visit more efficient, please complete the attached health questionnaire before your visit. Please bring the completed health questionnaire with you for your first appointment with Dr. Holmes.

MAMMOGRAMS: **Bring your Mammograms Images and Printed mammogram reports** from your mammograms performed over the last 3-5 years. Most Mammography or Breast centers will give you your mammogram images and reports on a Compact Disc (CD) or DVD. Other centers may give you your mammograms as large pieces of plastic film (see example below).

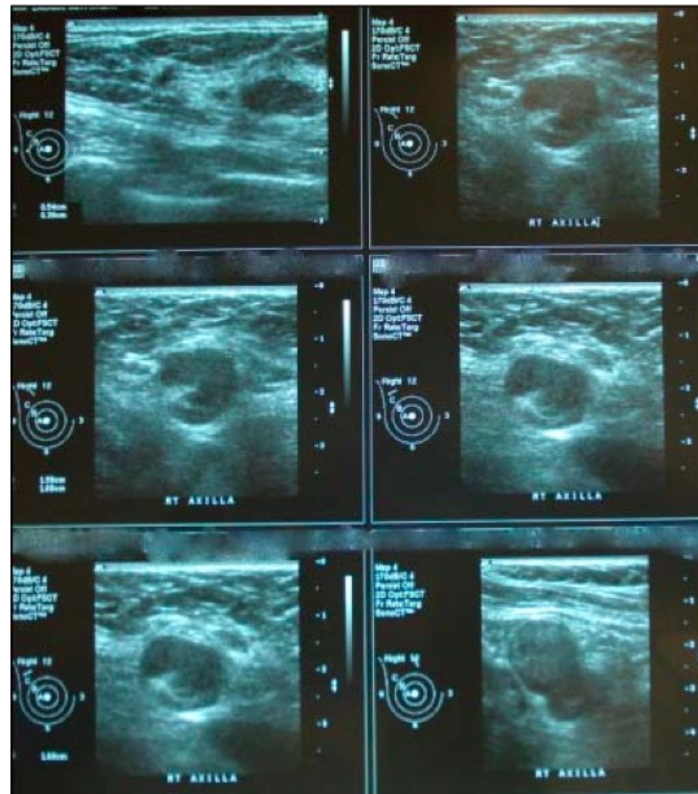
It is best that you hand-carry your mammogram images or CD to ensure their safe arrival to Dr. Holmes' office. However, you may have your mammograms films and reports sent directly to Dr. Holmes in advance of your appointment by UPS or FEDEX. The mailing address is listed below. Remember to obtain a tracking number.



Examples of Mammograms

ULTRASOUNDS: Bring your Ultrasound Images and reports from your ultrasounds performed over the last 3-5 years. Most Imaging or Breast Centers will give you your ultrasound images and reports on a Compact Disc (CD) or DVD. Other centers may give you your ultrasound as large pieces of plastic film (see example below).

It is best that you hand-carry your ultrasound images or CD to ensure their safe arrival to Dr. Holmes' office. However, you may have your ultrasound films and reports sent directly to Dr. Holmes in advance of your appointment by UPS or FEDEX. The mailing address is listed below. Remember to obtain a tracking number.



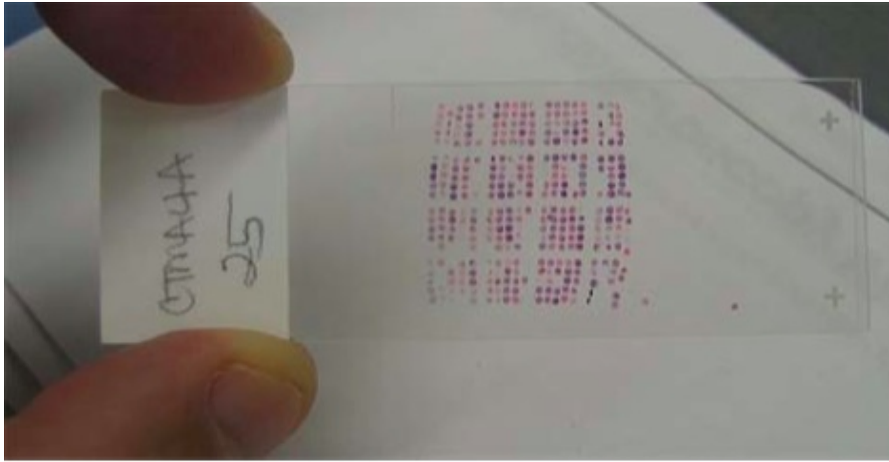
Example of Ultrasound

PATHOLOGY SLIDES: If you have already undergone a biopsy of your breast, Dr. Holmes will want to review a copy of your pathology report.

If you ultimately decide to have your breast surgery with Dr. Holmes, he will also want to review the actual pathology slides that contain the tissue that was removed from your breast so that the diagnosis can be confirmed by an independent breast pathologist.

Pathology slides are small, rectangular pieces of glass on which thin slices of your breast tissue have been applied (see example below). Please ask the office or lab that interpreted your pathology results to give you some of your slides for independent review. Two (2) to five (5) glass slides are usually placed in a small plastic box or cardboard tray to protect them from breakage.

It is best that you hand-carry the box of slides to ensure their safe arrival. However, you may also have them sent directly to Dr. Holmes in advance of your appointment using UPS or FEDEX. The address is listed below. Remember to obtain a tracking number.



Example of Glass Slide

CAUTION ABOUT BLOOD THINNERS: If a new or second breast problem is discovered during your visit with Dr. Holmes, it is sometimes necessary to perform a needle biopsy of the breast during your visit. To reduce the risk of bleeding from the wound during or after a needle biopsy, it is best that you stop taking aspirin, fish oil, and Ibuprofen-containing medications (e.g., Advil and Motrin) **at least 5 before your appointment**. These drugs may thin the blood and increase the risk of bleeding or bruising.

DO NOT stop taking Plavix, Coumadin (Warfarin), Fragmin, Xarelto or other oral or injectable prescription blood-thinning medications. If you are on one of these prescription blood thinners and if a breast biopsy is needed, Dr. Holmes will coordinate with your prescribing doctor the proper timing for discontinuing and resuming these medications.

MAIL / DELIVERY ADDRESS: Please use the following addresses if you plan to mail or courier your images and/or pathology slides to Dr. Holmes' office. Please make sure to send the images/slides to the correct office location. Also, please remember to obtain a tracking number for all deliveries.

Dennis R. Holmes, M.D.
c/o Pamela Simmons
1513 South Grand Avenue, Suite 400
Los Angeles, CA 90015
Phone: 818-539-1985 or 1-844-8CANCER
Fax: 818-539-1985

YOUR HEALTH CARE TEAM

Please list the contact information of all of the healthcare providers whom you would like to receive a copy of Dr. Holmes' consultation report (see example).

Doctor's Name	Specialty	Address	Phone Number Fax Number Email Address
(Example) *Dr. Alan Smith*	*Gynecology*	*2400 Main Street, Suite 400* *Los Angeles, CA 90025*	*Phone:* *555-214-5400* *Fax:* *555-205-5300* *Email:* *asmith@gmail.com*
			Phone: Fax: Email:
			Phone: Fax: Email:
			Phone: Fax: Email:
			Phone: Fax: Email:

HEALTH QUESTIONNAIRE

Name: ________________________________

Date of Birth: ________________________________

Date completed: ________________________________

Dear Patient,

In order to offer optimal care for you, we need to understand your complete health status and history. With this goal in mind, we appreciate you spending twenty minutes to complete this comprehensive health questionnaire.

Review of Systems

For the **Review of Systems** section, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example .... ● Yes ○ No

General

Chills .... ○ Yes ○ No

Fever.. ○ Yes ○ No

Night sweats .... ○ Yes ○ No

Sleep disturbance .... ○ Yes ○ No

Frequent or persistent headaches .. ○ Yes ○ No

Change in appetite .... ○ Yes ○ No

Weight gain .... ○ Yes ○ No

Weight loss.................... ○ Yes ○ No

Lightheadedness........... ○ Yes ○ No

Fatigue .... ○ Yes ○ No

Skin

Acne.. ○ Yes ○ No

Rash .... ○ Yes ○ No

Dry skin .... ○ Yes ○ No

Discoloration .... ○ Yes ○ No

Behavioral

Anxiety .... ○ Yes ○ No

Mental or Physical abuse................ ○ Yes ○ No

Auditory/visual hallucinations.......... ○ Yes ○

Depression.................... ○ Yes ○ No

Suicidal thoughts........... ○ Yes ○ No

Eating disorder .... ○ Yes ○

No

No

Neurologic

Numbness or tingling in hands or feet O Yes.. O No

Difficulty balancing / frequent falls .. O Yes O No

Tremor .... O Yes O No

Pain... O Yes O No

Memory loss.................. O Yes O No

Fainting .... O Yes O No

Seizures .... O Yes O No

Dizziness....................... O Yes O No

Endocrine

Heat intolerance.............................. O Yes O No

Cold intolerance.............................. O Yes O No

Excessive thirst .... O Yes O No

Eyes

Blurred vision .... O Yes O No

Decreased vision........... O Yes O No

Ear Nose Throat

Decreased hearing .... O Yes O No

Ringing in the ears.......................... O Yes O No

Ear pain .... O Yes O No

Sinus pain or infection .... O Yes O No

Frequent nosebleed........................ O Yes O No

Dry mouth...................... O Yes O No

Difficulty swallowing ...... O Yes O No

Sore throat .... O Yes O No

Swollen glands .... O Yes O No

Allergy

Itching .... O Yes O No

Hives.. O Yes O No

Sneezing .... O Yes O No

Respiratory

Wheezing....................................... O Yes O No

Shortness of breath at rest .... O Yes O No

Non-productive cough.... O Yes O No

Productive cough .... O Yes O No

Shortness of breath with exertion ... O Yes O No

Cardiovascular

Shortness of breath when lying flat. O Yes O No

Irregular heartbeat .... O Yes O No

Palpitations .... O Yes O No

Chest pain at rest .... O Yes O No

Chest pain with exertion O Yes O No

Ankle swelling .... O Yes O No

Peripheral Vascular

Decreased sensation in hands or feet O Yes... O No

Cold hands or feet .... O Yes O No

Foot ulcers .... O Yes O No

Leg pain when elevated O Yes O No

Breast

Breast pain.................................... O Yes O No

Enlarged lymph nodes .... O Yes O No

Breast lump.................................... O Yes O No

Skin redness .... O Yes O No

Nipple discharge .... O Yes O No

Gynecologic

Hot flashes.................................... O Yes O No

Vaginal discharge / itching.............. O Yes O No

Vaginal bleeding between periods.. O Yes O No

Painful intercourse .... O Yes O No

Irregular periods .... O Yes O No

Missed periods .... O Yes O No

Heavy periods .... O Yes O No

Painful periods .... O Yes O No

Gastrointestinal

Heartburn / indigestion.................... O Yes O No

Nausea .... O Yes O No

Abdominal pain .... O Yes O No

Vomiting... O Yes O No

Constipation .... O Yes O No

Diarrhea .... O Yes O No

Blood in stool................. O Yes O No

Rectal bleeding .... O Yes O No

Urinary

Frequent urination / incontinence ... O Yes O No

Blood in urine .... O Yes O No

Change in force of stream .... O Yes O No

Pain in lower back......... O Yes O No

Painful urination.............................. O Yes O No

Hematology (Blood)

Easy bruising .... O Yes O No

Prolonged bleeding .... O Yes O No

Musculoskeletal

Joint stiffness.................................. O Yes O No

Leg cramps .... O Yes O No

Swollen joints.................................. O Yes O No

Muscle aches .... O Yes O No

Painful joints .... O Yes O No

Social History

Household

Marital Status.......... O Single O Married O Widowed O Divorced

Alcohol Consumption

Frequency........ O Less than 1 drink per week O 2-3 drinks per week
O 1 drink per day O 2 or 3 per day O More than 3 per day

Tobacco Use

Non smoker .... O
Former smoker .... O
Current smoker............................... O

If 'current smoker' : how often do you smoke cigarettes?

O Every day O some days, but not every day

If 'current smoker' : how many cigarettes a day do you smoke?

O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more

If 'current smoker' : How soon after you wake up do you smoke your first cigarette?

O within 5 minutes O 6-30 minutes O 31-60 minutes O after 60 minutes

If 'current smoker' : Are you interested in quitting?

O Ready to quit O Thinking about quitting O Not ready to quit

Drugs

Have you used drugs other than those for medical reasons in the past 12 months? O
Yes...O No

Medical History

For Medical History, please indicate if you have ever been diagnosed with any of the following conditions.

Medical History

Hypertension.................................. O Yes O No

Coronary artery disease .... O Yes O No

Type I diabetes .... O Yes O No

Type II diabetes .... O Yes O No

Diabetes Mellitus .... O Yes O No

Asthma.. O Yes O No

Arthritis .... O Yes O No

Glaucoma .... O Yes O No

Kidney stones............... O Yes O No

Varicose veins .... O Yes O No

Heart murmur .... O Yes O No

Autoimmune disorder ... O Yes O No

Surgical History

Month / Year	Surgery

List additional on the last page

Hospitalizations

Month / Year	Reason

List additional on the last page

Allergies

Substance	Reaction

List additional on the last page

Current Medications

Please list all medications you currently take. Include the dose and how often you take the medication. Please also include any vitamins or herbal substances you are currently taking.

Name	Strength	Qty	Frequency	Start Date	Stop Date

List additional on the last page

Family History

Some cancers run in families. Information about all the cancer cases in your family tree can help us assess your risk of developing certain types of cancer. For each person who had cancer in your family (blood relatives to you only) please write in the age at which the cancer was found under the appropriate cancer type column

Family Members	Status alive, deceased, unknown	Year of birth	Cancer History Age at which cancer was identified							
			Breast	Ovarian	Uterus	Colon	Colon Polyps	Stomach	Pancreas	Other
Father										
Mother										
Siblings										
Children										
Paternal grand father										
Paternal grand mother										
Maternal grand father										
Maternal grand mother										
Paternal uncle										
Paternal aunt										
Maternal uncle										
Maternal aunt										
Spouse										

Family Members	Medical Conditions
Father	
Mother	
Siblings	
Children	
Paternal grand father	
Paternal grand mother	
Maternal grand father	
Maternal grand mother	
Paternal uncle	
Paternal aunt	
Maternal uncle	
Maternal aunt	
Spouse	