Georgia Breast Care

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:** _____

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 **Alcohol use:** 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 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, 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**