TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

Name:_____ **Date of Birth:**_____

Age:_____ **Sex:** Male Female

Referring Physician:_____

Primary Physician:_____

OB/GYN:_____

Please state in your own words the reason for your visit.

_____

Please indicate any medical problems you have:

___Hypertension ___Diabetes Mellitus ___Heart Disease ___Psychiatric History

___Asthma ___Reflux/Indigestion ___Thyroid Problems ___Bleeding Problems

___Prior Cancer (please describe below)

Other: _____

_____

_____

Please list all prior surgeries and approximate dates:

_____

_____

_____

Reproductive History:

Last Menstrual Period_____ Age of First Period_____

Number of Pregnancies_____ Number of Births_____

Any Miscarriages/Abortions_____ Age of First Delivery_____

Age at Menopause_____

Did You Breastfeed	Y	N	For How Long_____
Oral Contraceptive Use	Y	N	For How Long_____
Hormone Replacement Therapy	Y	N	For How Long_____
Any Prior Chest Radiation	Y	N	Age/Reason_____

Social History (please circle the appropriate response):

Employment: Yes No Retired Occupation:_____

Marital Status: Single Married Divorced Other:_____

Do you now or have you ever smoked? Yes No

If Yes, I started at the age_____, quit age_____.

Cigarettes, _____packs per day.

Do you want information on smoking cessation? Yes No

Do you drink alcohol? Yes No

If Yes, how many drinks per week. _____

Please list drug allergies and reactions:

_____

_____

_____

Medications/Vitamins/Supplements:

_____

_____

_____

I certify that this information is correct to the best of my knowledge.

Patient Signature:_____ Date: _____

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Name:_____ **Today's Date:**_____

Date of Birth:_____

Please indicate any symptoms you are experiencing.

General:
___chills
___fatigue
___night sweats
___weight gain > 10lb
___weight loss < 10lb

Cardiovascular:
___chest pain
___irregular heartbeat
___rapid heartbeat
___swelling of extremities

Psychiatric:
___anxiety
___depression
___insomnia
___panic attacks

Skin:
___bruising
___rash
___color change

Respiratory:
___chronic cough
___shortness of breath
___wheezing

Endocrine:
___cold intolerance
___heat intolerance
___hair changes
___hot flashes
___libido changes

HEENT:
___headache
___hearing change
___sore throat
___dry mouth

Gastrointestinal:
___abdominal pain
___change in bowel habit
___constipation
___diarrhea
___nausea/vomiting

Hematology:
___anemia
___easy bruising
___prolonged bleeding
___enlarged lymph nodes
___nose bleeds

Eyes:
___nearsighted/farsighted
___glasses/contacts
___glaucoma
___cataracts

Musculoskeletal:
___muscle pain
___bone pain
___joint pain

Neurologic:
___numbness
___weakness
___tremors

Neck:
___mass
___lumps
___swollen glands

Immunology:
___scleroderma
___rheumatoid arthritis
___lupus

Other Symptoms:
_____
_____
_____

Female Genitourinary:
___abnormal vaginal bleeding
___menstrual irregularities
___pelvic pain
___urinary complaints
___menstrual irregularities

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Hereditary Cancer Intake Form

Patient:_____ DOB:_____ Date:_____

This form will help determine whether there is an increased risk of hereditary cancer in your family. Individuals with hereditary cancer are at increased risk to develop multiple cancers, and their family members are at increased risk for cancer. If you have a hereditary form of cancer, it may be managed differently. This form will be reviewed by a genetics specialist who may not be familiar with your medical history, so we kindly ask that you fill it out entirely.

Are you adopted and/or unaware of your family history? (circle one) Yes / No

	If diagnosed with cancer, what kind(s) of cancer? If you are unsure of the type of cancer an individual has had, write 'unk'.	At what age(s) were they diagnosed? (best guess)
You		
Your sister(s) and brother(s)		
Your niece(s) and nephew(s)		
Your mother		
Your mother's parents, sister(s) and/or brother(s)		
Your maternal 1st cousin(s)		
Your father		
Your father's parents, sister(s) and/or brother(s)		
Your paternal 1st cousin(s)		
Your child(ren)		
Your grandchild(ren)		

- Has anyone in your family been diagnosed with more than one type of cancer? Yes / No
  If yes, please circle the cancers that this applies to in the chart above.
- Has anyone in your family been diagnosed with a hereditary cancer syndrome, such as a BRCA mutation or Lynch syndrome? Yes / No
  If yes, which hereditary cancer syndrome?_____
- Have any males in your family been diagnosed with breast cancer: Yes / No
- Are you of Jewish ancestry? Yes / No
  If yes, is your mother, father, or both of Jewish ancestry?_____
- Have you or any of your family members had more than 20 colon polyps? Yes / No

Patient's Initials_____ **Date**_____

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Patient:_____ **MRN:**_____ **Date:**_____

In the event Texas Breast Specialists/Texas Oncology needs to contact you about your medical care, but is unable to reach you directly, we would like to know if we are allowed to attempt any of the following commonly requested alternatives. Before you check one or more of the options below, please be mindful that these messages may include information about your test results, medications, insurance coverage, billing information, appointment details, or other personal information regarding your care at our practice.

If unable to contact me directly, I authorize Texas Breast Specialists/Texas Oncology to:

_____ Leave a voicemail message at this phone number:

_____

_____Speak to my spouse or significant other (name and relationship)

_____

_____Speak to or leave a message with the individuals listed below

Name:_____ Relationship to Patient:_____ Contact Number:_____

Name:_____ Relationship to Patient:_____ Contact Number:_____

Name:_____ Relationship to Patient:_____ Contact Number:_____

I understand that if I should decide to no longer authorize Texas Breast Specialists/Texas Oncology to share my information with any of the individuals listed above or leave a voicemail at the numbers indicated, that it will be my responsibility to notify the office in writing.

Print Patient Name:_____

Date of Birth:_____

Signature of Patient or Representative:_____

Date:_____

Relationship to Patient:_____

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Accidental Exposures

Patient Name: _____ **MRN:** _____ **Date:**_____

During the course of care and treatment, healthcare workers may be accidentally exposed to a patient's blood and/or body fluids. Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures.

I understand, in the event a healthcare worker is exposed to my blood and/or body fluids, my blood will be tested for the HIV antibody and other communicable diseases at no cost to me. My initials below signify that I understand and agree to this information.

Patient Initials _____ **Date** _____

Pregnancy

Female patients, please let us know if there is any possibility you may be pregnant.

Yes _____
No _____

Patient Initials _____ **Date** _____

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Patient: _____ **MRN:** _____ **Date:** _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.**
- **Formulary and benefit transactions- Gives the prescriber information about which drugs are covered by the drug benefit plan.**
- **Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.**

By signing this consent form, you are agreeing that Texas Breast Specialists/Texas Oncology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Texas Breast Specialists/Texas Oncology to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____

Date of Birth _____

Signature of Patient or Patient Representative _____

Date _____

Relationship to Patient _____

Pharmacy Name and Phone Number _____

Pharmacy Address _____