Here is a checklist of what you'll need to bring to your initial visit. Dr. Chiantella needs to have all the appropriate films and other medical information listed below in hand at your visit to thoroughly complete your initial evaluation and provide you the best care possible, so if clinical information or films are missing, your appointment will need to be rescheduled. Please read each item carefully, and call the office with any concerns or questions.

1-The attached forms:

Please complete the following pages as best you can. We will be glad to assist you in the office with any item about which you have questions. If you prefer to complete the forms in the office before your visit, please arrive about 30 minutes in advance of your appointment time to have ample time to complete the forms and be registered. If you would like more personal help with these forms. our Medical Assistant will be most happy to assist you in completing them when you come in, so just come in a bit early.

2-Your mammogram/ultrasound/MRI pictures:

Please bring any current mammograms you have had done, any breast ultrasound images, and any breast MRI images.

***THIS IS EXTREMELY IMPORTANT*: It is fine to have Ultrasound and MRI images on a computer disk, but mammogram images need to printed on actual pieces of film, as the resolution of a regular computer is not at all sufficient to see subtle mammogram findings.**

Please bring all current breast film studies, mammograms, breast ultrasounds, or MRIs, *and as many of your previous breast studies as you can. Three years' worth would be great.* Dr. Chiantella needs to see the same images that the radiologists have seen. The more prior years you can easily get, the better. If you are unsure of which films to bring, please give the office a call and we will gladly assist you.

You will need to call the imaging center in advance to have your films prepared for pickup. The more advance notice for the imaging center, the better chance you have of being given everything that you need. Since many studies are stored digitally, you must be very explicit in telling the center to print 3 years' of mammograms, or else they will only give you a single year, which is insufficient.

Do NOT plan on picking up your films on the way to your appointment, as experience on our end proves that rarely goes as planned, and we hate the inconvenience to all involved by having to reschedule your appointment.

BEFORE YOU LEAVE THE IMAGING CENTER, you will need to *look at the contents of the film jacket with the imaging center staff*, to make sure the current and prior years' films are actually in the film jacket, along with the typed radiologists' reports. It is unfortunate that too frequently there are missing x-ray studies, even when the patient has called ahead with her film request, and the omission of films is not discovered until she arrives at the office, and the visit has to be rescheduled.
Lastly, it is a common misunderstanding on the part of patients, that their referring physician, or the imaging center, has sent their actual films to our office in advance of their visit. We do often receive reports from these sources in advance, to help us plan the appropriate timing and length of your visit, but not actual films. If you are uncertain if we might already have the actual films in our office, please just call us before your visit for clarification.

3-Your insurance card. If you do not have health insurance, please let us know in advance of your appointment, so we can work with you on mutually acceptable arrangements.

4-A photo I.D.

5-A written referral from your referring physician IF ONE IS REQUIRED by your insurance.
We do accept credit cards as well as checks or cash for copayments and other fees.

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ____________ (First) ________ (MI) ____ Previous Name ____________

Address Line 1 ____________________________

City, State ____________ ZIP ________

Home Phone ________ Cell No. ________ Work Phone ________ Ext. ______

Primary Care Provider (PCP) ____________ Referring Provider ____________

Rendering Provider Name (this practice) ____________ E-Mail Address: ____________

Date of Birth MM ______/DD ______/YYYY ________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ ________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-______ Employer Name ____________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ____________ First Name ____________

Phone Number ____________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____________ ☐ Guardian

Address Line 1 ____________________________

City, State ____________ ZIP ________

Home Phone ____________ Work Phone ____________ Ext. ______

Referring Provider Name ____________________________

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ____________ (First) ____________ (MI) ______

Guarantor Account Number ____________ Date of Birth MM ______/DD ______/YYYY ________

Social Security Number _____-_____-______ Telephone ____________

E -Mail Address ____________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____________________________

City, State ____________ ZIP ________

Employer____________ Employer Phone Number____________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ Date of Birth MM ______/DD ______/YYYY ______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ Date of Birth MM ______/DD ______/YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____________________ ***Date***________

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We are committed to providing you with the best possible care. If you have medical insurance, we strive to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE PROVIDED

We accept cash, checks and Visa/MasterCard. We will be happy to process claims for those PPO's and HMO's with which we participate, but you will be expected to pay any copay or percentages of deductibles at the time of service. We participate with most major carriers and therefore will file the claim on your behalf. For other insurance companies, you are responsible for all fees at the time services are provided. We will provide you with information so you may file with your insurance company.

We must emphasize that as medical providers, our relationship is with you and not your insurance company. All charges are your responsibility from the date the services are rendered. If someone else is presumed liable for a bill, such as a divorced spouse or parent, we will look to the patient or if a minor, the guardian, for payment of services. We gladly provide you with a receipt for payment. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly, and prior to your office visit, for assistance in the management of your account.

Returned checks and balances older than thirty days may be subject to additional collection fees. We will gladly discuss your charges prior to your visit, as well as, any relating to your insurance. You must realize, however, that:

1- Your insurance is a contract between you, your employer, and the insurance company.
2- Not all services are a covered benefit in all contracts. You may wish to contact your insurance carrier for information regarding coverage. For example: Many insurance companies do not cover routine exams or supplies, such as crutches.

Please help us by updating your registration sheet with the receptionist when changes occur such as new employer, insurance or new home address. If you have any question about our office, please do not hesitate to ask. We are here to help you.

Initials ___________

______________________________________ agree that I am fully responsible for my bill if at any time my insurance denies payment. I am responsible for making sure my insurance is currently active and participating with the provider that I am seeing. If I am seeking urgent care treatment, I agree that I will pay the urgent care co-pay that has been established by my insurance company. I also agree that if I have a balance after my insurance has paid, that I will be responsible for the remaining balance due.

______________________________________ ______________________________

Patient Signature Date

How did you hear about our office?

Physician Referral (Name)	___________	Insurance Assignment	___________
Emergency Room	___________	Personal Reference	___________
Mailbox Flyer	___________	Signs	___________

The following form is used for you to tell us with whom we may communicate regarding your care, other than the physician who referred you, or your insurance company.

If we are allowed by you, for instance, to communicate with your spouse or significant other regarding your medical information, you may list that person on the form, and their contact number.

Just to be clear, we do not initiate any contact with anyone on this form, unless you as the patient as us to do so for some reason. If someone other than you calls the office asking any information about you, we check this form and see if it is permitted by you for us to discuss your care with that person, before divulging any information at all. If the person calling isn't listed here, no information will be divulged, and if the person calling doesn't know your password, no information will be divulged.

You may also specify if it is permitted to leave any phone messages/voice mails, and if so, at which phone numbers.

It's all about protecting your privacy!

Reston
Breast Care Specialists

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name ______________________________ DOB ____________

Account or Med. Rec. #______________________

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions *(i.e.: may pick up meds, may disclose test results, etc)*	Patient/ Guardian Initials

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message at home with my spouse or:

NAME: ______________________________

RELATIONSHIP: ______________________DOB:__________

☐ Leave message on cell phone. Cell phone number: ____________________

☐ Leave message at work. Work phone number: ____________________

☐ Leave message on voicemail. Phone number: ____________________

☐ Leave a detailed message on answering machine. Phone number: ____________________

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: ______________________________

______________________________ Signature of Patient or Legal Guardian

______________________________ Date

______________________________ Printed Name of Patient or Legal Guardian

______________________________ Relationship *(if not self)*

TO ORDER CALL SAFEGUARD (804) 355-2679 • FAX (804) 359-8332 JMeagher@GoSafeguard.com

W09SF001104M 9/09

The next page is a release form to allow us to send your actual medical records to someone (another physician, etc.) other than your referring/regular physician.

We know you haven't asked for your records to be sent anywhere! However, if you should ever wish for us to do so, we cannot do that without your written consent.

The management group supporting Reston Breast Care Specialists deems that it is more convenient for the patient if we keep your signature on file on a blank request form, such that if you ever do need records transferred, all you need to do is call us, and we complete the form at your direction, and save you time and the inconvenience of having to come back to the office to give us a signature, or the wait time to mail signature forms out and back.

If you do not feel comfortable in signing a blank form, please don't do it. But if you would like this to be kept in your records, you only need to fill in the top line (Name, date, social security number), and sign and date the very bottom.

As always, please just ask if you have any questions.

Reston
Breast Care Specialists

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**
Provider's Name:	**Recipient's Name:**	
Provider's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** / **Zip:**

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event:
Date: **Event:**

Purpose of Disclosure:

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	Date of Service:	Description:	Date of Service:	Description:	Date of Service:
☐ All PHI in Medical Record		☐ Operative Information		☐ Labor/Delivery Summary	
☐ Admission Form		☐ Cath Lab		☐ OB Nursing Assess	
☐ Dictation Reports		☐ Special Test/Therapy		☐ Postpartum Flow Sheet	
☐ Physician Orders		☐ Rhythm Strips		☐ Itemized Bill:	
☐ Intake/Output		☐ Nursing Information		☐ UB-92 Claim:	
☐ Clinical Test		☐ Transfer Forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. There may be a reasonable fee to obtain a copy of the information being requested on this form.
7. I get a copy of this form after I sign it.
8. Note: There will be a charge for records in accordance with the VA code 8.01-413 $0.50 (Per page up to 50 pg) Additional $0.25 per page (from page 51 & up) + actual postage.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ or Personal Representative:	**Date Signed:**
Printed Name of Patient/Guardian/ or Personal Representative:	**Relationship of Personal Representative to Patient:**

Reston Breast Care Specialists

Consent for Treatment and Payment Agreement

I hereby authorize Reston Breast Care Specialists to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Reston Breast Care Specialists of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Reston Breast Care Specialists, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: ___________

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Reston Breast Care Specialists. Patient Initial: ___________

I request this authorization also apply to all other insurance. Patient Initial: ___________

I acknowledge that I have been given Reston Breast Care Specialists Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient Initial: ___________

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
______________________________	Y N	Y N
______________________________	Y N	Y N
______________________________	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature____

Date______________________________ **Patient Date of Birth**______________________

MEDICAL HISTORY FORM

NAME________________________________ AGE______ DATE COMPLETED_______________

PRIMARY CARE PHYSICIAN____________________________

OB/GYN_______________________________________

WHO REFERRED YOU? ___________________________________

I. WHAT IS THE REASON FOR TODAY'S VISIT? (Please check all that apply)

____I went for a routine visit, and my doctor felt a lump in ____my right ____my left ____both breast(s) and recommended follow-up.

____I found a lump in ____my right ____my left ____both breast(s).
When did you first notice this? ____

____I went for routine exam, my breast exam was fine, and I was sent for mammogram which came back abnormal.

____My mammogram shows a change when compared to my last mammogram.

____I have pain in ____my right ____my left ____both breast(s).
Please describe: ____constant ____cycles ____same spot ____location varies
When did you first notice this? ____

____I have nipple discharge from _____my right _____my left _____both breast(s)
Color: ____

When does this occur? ___spontaneously ___only when pressure is applied
_____ daily ___intermittently
When did you first notice the discharge? ____

____Other: (Please Specify) ____

II. SELF EXAMS I examine my breasts ____monthly ____intermittently ____rarely ____never.

III. PAST BREAST PROCEDURES

Have you ever had: (Please check all that apply)

____A cyst aspirated (fluid removed from the breast with a needle) ____right ____left
____A lump aspirated (a needle placed in lump that was solid, cells were sent to pathologist)
____right ____left

____A breast biopsy (a piece of tissue or lump removed) ____right ____left
Where was it done? ____
When was it done? ____
Results? ____

Have you had breast cancer? ____No ____ Yes
Do you have breast implants? ____No ____ Yes

IV. REVIEW OF SYSTEMS (Please only check symptoms that you **currently** experience)

Constitutional Symptoms ____Fever ____Night sweats ____Unexplained weight loss ___Unexplained weight gain
_____ Insomnia ____Migratory Pain ____ Other______________________________

Eyes ____Blindness ____Cataracts ____Glaucoma ____Retina Problem ____Other_________________

Ears, Nose, Mouth, Throat ____Earaches ____Ringing in the ears ____Dizziness
____Ear Problems ____Nose Bleeds ____Sinus Problems ____Change in voice
____Sore tongue/mouth ____Tooth problems ____Bleeding gums
____Sore throat ____Painful swallowing ____Difficulty swallowing ____Other ________________________

Cardiovascular ____Heart disease ____High blood pressure ____Poor circulation ____Chest Pain
____Ankle swelling ____Leg pain while walking ____Rheumatic fever ____Fast heart beat _____Phlebitis ____Irregular heartbeat ____Heart Attack ____Other______________________

Respiratory ____Asthma ____Chronic cough ____Coughing up blood ____Emphysema
____Tuberculosis ____Short of breath ____Pneumonia ____Other lung problems _____________

Gastrointestinal ____Esophagitis ____Decreased appetite ____Difficulty swallowing ____Gastritis ____Hiatal hernia
____Ulcers ____Acid reflux ____Nausea/vomiting ____Vomiting blood ____Gallstones ____Liver disease
____Cirrhosis ____Hemorrhoids ____Anal problems ____Hepatitis ____Constipation ____Diarrhea ____Irritable bowel
____Bloody stools ____Diverticulosis ____Polyps ____Black stools
____Gluten intolerance/celiac disease ____Other stomach or intestinal/colon problems_______________________________

Urinary ____Kidney stones ____Kidney infection ____Painful urination ____Blood in urine ____Urine leakage
____Bladder infection ____Low kidney function ____Other kidney/bladder problem______

Muscular/Skeletal ____Arthritis ____Osteoporosis ____Neck Pain ____Back pain ____Fibromyalgia ____Artificial joints ____Disc problems ____Other muscle/bone problems__________________________

Skin ____Psoriasis ____Eczema ____Skin Cancer
____Melanoma ____Rashes ____Pre-Cancerous areas
____Other skin problems____

Nervous System ____Migraines ____Slurred speech ____Numbness
____Other Headaches ____Stroke/CVA ____Mini-stroke/TIA
____Seizures ____Weakness on one side ____Temporary blindness
Other brain or nerve problems ____

Psychiatric ____Depression ____Anxiety ____Bipolar ____Drug/Alcohol problem
____Other psychiatric conditions____

Endocrine ____Diabetes ____Hypoglycemia ____Goiter/thyroid surgery
____Low thyroid ____Hyperthyroid ____Other______________________

Blood/Lymph Systems ____Anemia ____Enlarged lymph nodes ____Easy bruising
____Bleeding disorder ____Blood clots ____Sickle cell disease/trait ____Other blood or lymph gland problems_______________

Allergy/Immune System/Infectious disease ____Immune deficiency ____Plant/animal allergy ____HIV
____Current allergy shots ____History of MRSA
____Other immune/allergy/infection problems (specify) ____________________________

Any complaints not listed above? ____

V. REPRODUCTIVE HISTORY

A. Menstruation and Pregnancy

Age periods started: ________________________
Number of pregnancies: ____________________
Number of live births: _____________________
Age at first live birth: _____________________
Are you pregnant now? ____No ____Yes If yes, number of weeks: _______
Age at menopause: _________________________
If you are before menopause, when was your last period?___________________
Any recent change in your periods? ____No ____Yes
If yes, please describe: ____

B. Have you ever breast fed? ____No ____Yes

If yes, number of children_______ total number of months ____

C. Have you had a hysterectomy?

____No
____Yes, including removal of both ovaries
____Yes, but one ovary, or a piece of ovary, was not removed.
____Yes, but neither ovary was removed.
____Yes, but I don't know if my ovaries were removed.

Age at hysterectomy________
Reason for hysterectomy: (Please check all that apply)
____Abnormal bleeding
____Endometriosis
____Fibroids
____Pelvic infections
____Uterine cancer
____Bladder problems
____Pre-Cancer of Cervix
____Cancer of Cervix
____Pelvic Pain or Adhesions
____Other Reason: _________________________________

D. Oral Contraceptive Use

Have you ever used birth control pills? ____No ____Yes
How many years of use? Less than one year ______
1-5 years ______
5-10 years ______
10-15 years ______
15+ years ______

Are you currently using them? ____No ____Yes

____I was on birth control pills mainly to regulate my periods.

E. Women's Cancer Screening

When was your last pelvic/internal exam? ______________________________________

When was your last PAP? ____

F. Estrogen Replacement

Have you ever used estrogen replacement? (This includes vaginal cream. Does not include oral contraceptives)
____No ____Yes

How many years of use? Less than one year ______
1-5 years ______
5-10 years ______
10-15 years ______
15+ years ______

Are you using it currently? ______No ______Yes

Estrogen replacement was being used for: (Please check all that apply)

____to control bleeding
____to control hot flashes
____to control vaginal/pelvic pain
____I am not sure
____to control moods
____to control sleep disturbance
____to ease menopausal symptoms after hysterectomy
____Other reason____________________________

Please list your current hormone medication(s) and dose(s):_________________________
Has the type or dose been changed recently? ____No ____Yes

G. Fertility Drugs

Have you ever taken fertility drugs? ____No ____Yes
If yes, are you taking them now? ____No ____Yes

VI. FAMILY HISTORY

____There is no one in my family that I know of with a history of cancer.

My family history is positive for: (Please list relationship to you) (Include father's side)

Breast Cancer ____

Ovarian Cancer____

Uterine Cancer____

Colon Cancer __________________________ Other Cancer ________________________

Has any family member been tested for the "breast cancer gene" (BRCA 1 or 2 genes, or BRACAnalysis)?
_______No _______Yes _______Don't know

VII. SOCIAL HISTORY/HABITS

A. Have you ever smoked? ____No ____Yes If yes, how many packs per day?______
For how long? __________years
If you are no longer smoking, how many years ago did you quit? _______years

B. How many alcoholic beverages do you consume weekly?________

C. Does your consumption of caffeine and chocolate equal more than 5 servings per day? _____No ______Yes

D. Please list your race or ethnic group _________________________________.
Are you of Ashkenazi (Eastern European Jewish) descent? ____No ____Yes

Additional Medical Information

Please list your past medical illnesses:

____

____

____

Please list previous **surgical procedures** and dates:

____

____

____

Please list your:

Height ______ft______inches

Weight_______________lbs

Bra Size _________________

YOU'RE ALMOST DONE!!

Please list your current PRESCRIPTION medicines/doses and the reason for use:

Medicine/dose	Reason for use:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Please list any NON-Prescription drugs, herbs, or supplements currently used:

Drug/Herb/Supplement Type	Reason for use
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Are you taking daily aspirin therapy? ____No____Yes

Have you ever had a blood transfusion? ____No____Yes
When and Why? ____

Have you ever had any radiation treatments? ____No____Yes

Have you taken steroid medication or immune suppressing medications in the last 6 months?
____No ____Yes

Are you allergic to, or sensitive to, LATEX or latex-containing items? ______No ______Yes
If yes, please describe reaction: ______________________________________

Has your skin reacted badly to adhesives, tapes, band-aids, or sutures? ______No ______Yes

Please list DRUG allergies: ______None known

Drug	Type of reaction
____________________	____________________
____________________	____________________
____________________	____________________