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NORTHWEST ARKANSAS
BREAST CARE SPECIALISTS

PATIENT REGISTRATION FORM

Patient Name (Last) _____ (First) _____(MI) _____

DOB:_____ Ethnicity: _____ SS#: _____

Address: _____City/St/Zip:_____

Phone #: (home) _____ Cell: _____Email: _____

Male ❑ Female ❑ Marital Status: M ❑ S ❑ D ❑ W ❑

Employer: _____ Phone#:_____

Occupation: _____ Work Status: Full time ❑ Part time ❑ Retired ❑

Primary Care Physician: _____ Gynecologist:_____

Responsible Party Name: _____ Relationship to patient:_____

How will the bill be paid today? _____

EMERGENCY CONTACT(RELATIONSHIP):_____Phone#:_____

Who referred you to our office:_____

How Did You Hear About Us? Friend ❑ Internet ❑ Advertisement ❑ My Doctor ❑

Do you have a living will? Yes ❑ No ❑ Pharmacy Name:_____ Ph#:_____

Primary Insurance Company: _____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy#: _____ Group#: _____

Co-pay: _____ Deductible: _____ Effective Date of Coverage:_____

Secondary Insurance Company:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy#:_____Group#:_____

I certify that the information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Northwest Arkansas Breast Care Specialsists. I authorize release of medical information necessary to process this claim. I also acknowledge receipt of the Notice of Privacy Practice of this clinic. I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: _____ Date: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Health History

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

Why are you seeing Dr. Menendez today? _____

Who is your primary doctor?: _____ **OB/Gyn Doctor?:** _____

YOUR Reproductive Health History

How old were you when your menstrual periods began?	_____ years old
Date of last menstrual period _____	Date of last pap smear? _____
Are you currently pregnant? ❑ YES ❑ NO	Are you currently breastfeeding? ❑ YES ❑ NO
Number of pregnancies _____	Number of living children _____
How old were you when you had your first child? _____ years old ❑ Not Applicable Did you breast feed? ❑ YES ❑ NO	Have you ever taken birth control pills? ❑ YES ❑ NO If yes, how long _____
Have you gone through menopause? ❑ YES ❑ NO ❑ Just beginning ❑ Currently ❑ Postmenopausal If yes, at what age did you begin menopause? _____	Have you had your uterus removed? ❑ YES ❑ NO If yes, reason _____
Have you had your ovaries removed? ❑ YES ❑ NO If yes, reason _____ ❑ ONE ❑ BOTH	Have you ever taken hormone replacement therapy? ❑ YES ❑ NO If yes, how long? _____ Type: _____
Have you ever had a breast biopsy? ❑ YES ❑ NO If yes, how many? _____	Result of last biopsy: ❑ Benign ❑ Malignant ❑ In-Situ ❑ Invasive
Have any biopsies revealed "atypical hyperplasia"? ❑ YES ❑ NO ❑ UNSURE	Have any biopsies revealed "lobular neoplasia"? ❑ YES ❑ NO ❑ UNSURE

Allergies – List ALL allergies to medications/foods/substances (and reactions to each)

_____ _____

_____ _____

Medications – List ALL medications/vitamins/supplements you are currently taking

_____ _____

_____ _____

_____ _____

Review of Symptoms: Check symptoms you currently have or have had in the past year

Constitutional: ___ Chills ___ Fatigue ___ Fever ___ Night sweats ___ Weight loss ___ Weight gain ___ Insomnia **HEENT:** ___ Nose bleeds (epistaxis) ___ Headaches ___ Neck mass ___ Swollen glands **Respiratory:** ___ Cough ___ Difficulty Breathing	**Cardiovascular:** ___ Chest pain ___ Irregular heartbeat ___ Swelling of extremities **Gastrointestinal:** ___ Abdominal pain ___ Black, tarry stool ___ Change in bowel habits ___ Constipation ___ Diarrhea ___ Nausea ___ Vomiting **Genitourinary:** ___ Change in urine color ___ Painful urination ___ Blood in urine	**Female Genitourinary:** ___ Form of birth control: *Medication Tubal ligation* *Vasectomy Hysterectomy* ___ Absence of period ___ Painful menstruation ___ Excessive bleeding ___ Pelvic pain **Reproductive:** ___Breast lump: right or left ___ Breast pain: right or left ___ Breast swelling ___ Nipple discharge: right or left ___ Nipple pain: right or left	**Endocrine:** ___ Cold intolerance ___ Heat intolerance ___ Hair loss **Dermatology:** ___ Rash ___ Skin changes **Musculoskeletal:** ___ Muscle pain (myalgia) ___ Joint pain **Hematology:** ___ Easy brusing

Past Medical History – Check all that apply

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Diabetes	❑	❑	Cancer
❑	❑	Heart Attack	❑	❑	Kidney Disease			Type: _____
❑	❑	Alzheimer's Disease	❑	❑	High Cholesterol	❑	❑	COPD
❑	❑	Irregular Heart Rhythm	❑	❑	Asthma	❑	❑	Arthritis
❑	❑	Blood Clots (DVT/PE)	❑	❑	Tuberculosis (TB)	❑	❑	Osteoporosis
❑	❑	Heart Valve Disease	❑	❑	Heart Failure	❑	❑	Depression
❑	❑	Peripheral Vascular Disease	❑	❑	Other Blood Diseases	❑	❑	Hepatitis
❑	❑	History of Blood Transfusion	❑	❑	Anesthesia Problems	❑	❑	Angina
❑	❑	Inflammatory Bowel Disease	❑	❑	Seizures	❑	❑	HIV/AIDS
❑	❑	History of Radiation Treatment	❑	❑	Peptic Ulcer/Gastritis	❑	❑	Stroke
❑	❑	Connective Tissue Diseases	❑	❑	Thyroid Disease	❑	❑	Sleep Apnea
❑	❑	Anemia	❑	❑	Other Psychiatric Problems	❑	❑	Pacemaker

Other: _____

Previous Surgeries and Hospitalizations – list all operations and hospitalizations with dates

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Tobacco Use:
- ❑ Never Smoker
- ❑ Former Smoker – Years you smoked _____ Packs per day _____
- ❑ Current Smoker – Years you have smoked? _____ Packs per day _____

Caffeine Use: ❑ Soda ❑ Coffee ❑ Tea ❑ Chocolate
Amount consumed: _____(ex: 1 cup) How often? _____(ex: daily)

Alcohol Use: ❑ Beer ❑ Beer & Liquor ❑ Beer & Wine ❑ Gin ❑ Hard Liquor
❑ Methanol ❑ Rum ❑ Wine ❑ Scotch ❑ Vodka ❑ Whiskey

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature _____

Today's Date _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer†§
- ☐ Three or more HBOC-associated cancers at any age†§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
‡In the same individual or on the same side of the family
§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Hereditary Colon Cancer - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ 10 or more cumulative colorectal adenomas at any age

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome, MAP, AFAP, or FAP syndrome mutation in the family
- ☐ One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED
Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____