OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

OHC BREAST SURGICAL ONCOLOGY

FEMALE NEW PATIENT INTAKE FORM

First name: _____ Last name: _____

Today's date: _____ DOB: ____/____/____ Age: _____ SS: (Last 4 digits): _____

Reason for visit: _____

Referring doctor: _____ Primary care doctor: _____

Are you planning to bring anyone to your visits, if so, name/relationship:

_____

Have you ever had any breast problems? ❍ Yes ❍ No

If yes, please describe (cancer, pain, nipple discharge, abscess, cysts, other): _____

Have you ever had a breast biopsy? ❍ Yes ❍ No Year _____ Where? _____

If yes, results: ❍ Normal/Benign ❍ Hyperplasia (not atypia) ❍ Atypical hyperplasia

❍ Lobular Carcinoma in Situ (LCIS) ❍ Unknown ❍ Other _____

Have you had any breast surgery? ❍ Yes ❍ No If yes, Year: _____ Type of surgery: _____

Reason: _____ Where: _____

Have you ever had radiation treatment to your chest area and/or to a breast? ❍ Yes ❍ No

Bra size: _____ Height: _____ Weight: _____

Medical History – Please check all that apply or have applied in the past

- ❍ Headaches
- ❍ Stroke
- ❍ Thyroid problem
- ❍ Diabetes (Type I or II)
- ❍ Atrial fibrillation
- ❍ Congestive heart failure
- ❍ Heart disease/Heart attack
- ❍ High blood pressure
- ❍ High cholesterol
- ❍ Asthma
- ❍ COPD/Emphysema
- ❍ Sleep apnea
- ❍ Bleeding disorders/Anemia
- ❍ Kidney problems
- ❍ Liver problems
- ❍ Hepatitis
- ❍ HIV/AIDS
- ❍ Alcoholism
- ❍ Arthritis/Gout
- ❍ Epilepsy/Seizures
- ❍ Testicular mass/Tumor
- ❍ Lupus/SLE
- ❍ Collagen vascular disease
- ❍ Scleroderma
- ❍ Cancer (type: _____)

Please list any additional medical problems and/or surgeries you have had:

_____

_____

Please list any allergies:

_____

Do you currently take any of the following? ❍ Yes ❍ No (Mark all that apply)

❍ Aspirin ❍ Coumadin/Warfarin ❍ Eliquis ❍ Xarelto ❍ Plavix ❍ Other

Patient name: _____ DOB: ____/____/____ Age: _____ SS: (Last 4 digits): _____

OB/GYN History:

Age at first menstrual cycle _____ Last menstrual cycle (if applicable) _____

pregnancies _____ # births _____ Age at first live birth _____

Did you breast feed your child(ren)? ❍ Yes ❍ No ❍ N/A

Have you gone through menopause? ❍ Yes ❍ No Age: _____

Have you had a hysterectomy? ❍ Yes ❍ No Age: _____ Reason: _____

Have you had your ovaries removed? ❍ Yes ❍ No Age when ovaries were removed: _____ ❍ Unknown

Have you ever taken birth control pills? ❍ Yes ❍ No # of years _____ Still using? ❍ Yes ❍ No

Have you ever taken hormone therapy? ❍ Yes ❍ No, Still using? ❍ Yes ❍ No Stopped ___ years ago

If yes, medication: _____ # of years taken _____

Family History:

Have you ever had any genetic testing? ❍ Yes ❍ No Year _____ Results _____

Have any family members had testing? ❍ Yes ❍ No Who and results _____

Are you of Ashkenazi Jewish descent: ❍ Yes ❍ No Mother or father's side? _____

Please list anyone in your family who has had cancer:

Family member with cancer (ex. parents, siblings, paternal/maternal grandparents, aunts, uncles, and cousins)	Type of cancer	Age at diagnosis	Alive, current age	If deceased, age at death

How many of the following relatives do you have?

Maternal aunts ____ Paternal aunts _____ Daughters_____ Sisters _____ Half sisters (maternal/paternal) _____

Social History:

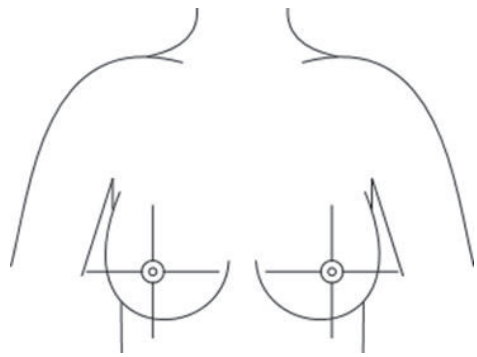
Alcohol use: ❍ Never ❍ Socially ❍ Daily # Drinks per day _____

Tobacco use: ❍ Yes ❍ No, ❍ Former smoker Quit date _____

If yes, # cigarettes/day _____ # years _____

Occupation: _____

For Internal Use Only.
Provider Notes:



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PATIENT LIST OF MEDICATIONS

Please list all medications that you are currently taking.
Include all over-the-counter medicines, vitamins and herbal supplements.
Please PRINT as clearly as possible.

Patient Name: _____ Date of Birth: _____

Allergies: _____

_____

Pharmacy Name: _____

Pharmacy Location: _____ Phone Number: _____

Name of Medication Brand or Generic Name	**Strength/Dosage** mg, units, puffs or drops	**Directions** How many times per day? Only as needed?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

Please bring all of the medication bottles with you to your appointment so that we can do a thorough review of your medications.