MARYLAND SURGEONS

Date_____

Patient Name:_____ Date of Birth: _____

BREAST HEALTH QUESTIONNAIRE

Do you examine yourself regularly? ___ Yes ___ No How often? _____

When do you examine yourself in relation to menstruation? _____

Do you see a physician for breast exams? ___ Yes ___ No How often? _____

Date of last check up: _____ Name of physician: _____

Have you ever had a mammogram? ____ Yes ____ No

Date of last mammogram: _____

Have you ever had nipple discharge? __ Yes __ No Which breast? ____ Left ____ Right

Any infection or injury to the breast? __ Yes __ No Which breast? ____ Left ____ Right

Any family history of breast cancer? __ Yes __ No If so, who? _____

Any previous breast surgery? __ Yes __ No When? _____

At what age did you start menstruation? _____ Date of last menstrual period:_____

How many pregnancies have you had? _____ How many children do you have? _____

How old were you at the birth of your 1st child? _____

Did you breastfeed? ____ Yes ____ No If yes, how long? _____

Do you take birth control pills? ____ Yes ____ No In the past? ___ Yes ____ No

If yes, how long? _____

Do you take hormones? _____ Yes _____ No If yes, how long? _____

At what age did you stop menstruating (menopause)? _____

MARYLAND SURGEONS

Date_____

Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex _____ Marital Status _____

Home Phone # _____ Work Phone # _____ Cell# _____

Employer _____ Preferred language:_____Race: _____

Email address: _____

Pharmacy: _____City: _____Pharmacy Phone #:_____

Person to Notify in an Emergency _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Referring Physician _____

Insurance Information:

Primary Insurance _____

Are you the policyholder? _____Yes ____No (*this information is NOT on the card*)
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance _____

Are you the policyholder? _____Yes ____No
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Other Health Care Providers

GYN Name_____Phone _____Fax_____

Gastroenterologist _____Phone_____Fax_____

Oncologist _____Phone_____Fax_____

MARYLAND SURGEONS

Date_____

ASSIGNMENT AND RELEASE:
I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medical information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
I authorize Saint Agnes Health to download my current medications for purposes of insurance payment.
I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities
I hereby consent to treatment by my Saint Agnes Health provider(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occured prior to the date of the revocation will not be affected.

By signing this consent, I authorize **St. Agnes HealthCare** and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name:_____ Relationship:_____

Method of Communication:_____

Name:_____ Relationship:_____

Method of Communication:_____

May we contact you regarding your protected health information, health status, appointments, and test results?

_Yes, you may contact me by e-mail; my address is:_____

_No, do not contact me by email for this purpose.

_Yes, you may contact me by phone; my daytime phone numbers are:
( )_____-_____ ( )_____-_____

_Yes, you may contact me at the following fax number ( )_____-_____
May we leave a message regarding your protected health information at the numbers you provided above?
__Yes __No

Signed_____ **Date:**_____

MARYLAND SURGEONS

Date_____

Name: _____ Primary Care Physician:_____

Date of Birth: _____ Age: _____ Referring Physician: _____

1. Reason for visit: _____Work related?_____

2. Do you have allergies to medications? ☐ No ☐ Yes
List medication & reaction (i.e. rash, trouble breathing)
_____

3. Any allergy to: ☐ latex; ☐ tape; ☐ betadine scrub; ☐ contrast (IV dye)? (check item if allergic)

4. Current medications (include dosage):

_____

_____

_____

5. Past or present medical problems: (check all that apply)

- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic cough
- ❑ Chronic lung disease
- ❑ Cirrhosis of the Liver
- ❑ Colon cancer
- ❑ Colon polyps
- ❑ Crohn's Disease
- ❑ Diabetes
- ❑ Diverticulitis
- ❑ DVT
- ❑ Emphysema
- ❑ Frequent UTI/ Kidney Infection
- ❑ Heart Attack
- ❑ Heart murmur/ Rhuematic Fever
- ❑ Hepatitis
- ❑ Hiatal hernia
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Irregular heart beat
- ❑ Irritable bowel syndrome
- ❑ Kidney disease/failure
- ❑ Multiple Sclerosis
- ❑ Ovarian cyst
- ❑ Pancreatitis
- ❑ Parkinson's disease
- ❑ Phlebitis
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Seizures
- ❑ Skin cancer
- ❑ Stomach/ duodenal ulcer
- ❑ Stroke or paralysis
- ❑ Thyroid disease
- ❑ Transfusions
- ❑ Ulcerative colitis

6. Past surgeries:

☐ NONE ☐ Appendectomy ☐ Gallbladder ☐ Hernia Repair ☐ Colon Resection ☐ Other: _____

7. Have you or any family member ever had a problem with anesthesia? ☐ No ☐ Yes

8. Family history:

	Father	Mother	Brother	Sister
a) Heart Trouble:	☐	☐	☐	☐
b) Cancer:	☐	☐	☐	☐
c) Diabetes:	☐	☐	☐	☐

9. Social history:

a) Tobacco use: ☐ never smoked ☐ smoker: how much_____ ☐ ex-smoker: quit when _____

b) Alcohol use: ☐ none ☐ rarely ☐ often ☐ daily

c) Occupation: _____

MARYLAND SURGEONS

Date_____

Patient Name: _____ Date Of Birth: _____

REVIEW OF SYSTEMS

Please circle any illness or problems that you are currently experiencing.

GENERAL	☐ NONE	Weight gain, Weight loss, other_____
EYES	☐ NONE	Change in vision, poor vision, other_____
EAR/NOSE/THROAT	☐ NONE	Sleep apnea, hearing loss, other:_____
RESPIRATORY	☐ NONE	Shortness of breath, wheezing, other:_____
CARDIOVASCULAR	☐ NONE	Chest pain with activity, pain in legs with walking, **Date of last** EKG_____, Stress Test_____, Echo_____, and/or Cardiac Cath: _____
GASTROINTESTINAL	☐ NONE	Blood in stool, yellow eyes/ skin, other:_____
GENITOURINARY	☐ NONE	Difficulty urinating, kidney stones, other:_____
MUSCULOSKELETAL	☐ NONE	Severe back pain, severe joint pain, other:_____
SKIN	☐ NONE	Rash, MRSA, other:_____
NEUROLOGICAL	☐ NONE	Severe headaches, pain/numbness in legs, other:_____
PSYCHIATRIC	☐ NONE	Depression, anxiety, other:_____
HEMATOLOGIC	☐ NONE	Blood clots, transfusions, other:_____
ENDOCRINE	☐ NONE	High blood sugar, excessive thirst, other:_____