Maryland Surgeons

Main: 443-574-8500

Fax: 443-708-9320

Name ______________________________ ______________ **Date of Birth** ______________

Last **First**

☐ Male ☐ Female

It is imperative that we are able to reach you in a timely manner in order to provide you with the best quality care. As a consideration for our staff and patients we ask that you provide effective contact information to our office.

The best number to reach me and leave messages regarding appointment reminders, medical information, or billing information is: (_________) _________-___________

This is my: ☐ Home phone ☐ Cell Phone ☐ Work Number ☐ Other

Past Surgical History: Please list all prior surgeries beginning with the most recent, use space on back if necessary.

1) ______________________________ Year __________
2) ______________________________ Year __________
3) ______________________________ Year __________
4) ______________________________ Year __________

Medical History: Please check any condition you have been diagnosed with.

☐ Arthritis ☐ Asthma ☐ Emphysema ☐ COPD ☐ Kidney Disease ☐ Thyroid Disease
☐ Diabetes ☐ Type I ☐ Type II ☐ High Blood Pressure ☐ Stroke ☐ Hepatitis ☐ HIV/AIDS
☐ Heart Problems ☐ Palpitations ☐ Chest Pain ☐ High Cholesterol ☐ Auto Immune Disorder
☐ Cancer ____________________ ☐ Other ____________________

Review of Symptoms: Please mark all that apply.

GENERAL:
- ☐ Weight Changes
- ☐ Fever/Chills
- ☐ Bleed/Bruise Easily
- ☐ Blood Transfusion
- ☐ Anemia

URINARY TRACT PROBLEMS:
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Pain with Urination

NEUROLOGICAL PROBLEMS:
- ☐ Seizures
- ☐ Head Injury Date: ______________ Type: ______________
- ☐ Headaches
- ☐ Numbness/Weakness Location: ______________

STOMACH PROBLEMS:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Heartburn
- ☐ Liver Disease

LUNG PROBLEMS:
- ☐ Cough
- ☐ Shortness of Breath

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Current Medications: Use back for additional medications.

1) ______________________________ Dosage __________
2) ______________________________ Dosage __________
3) ______________________________ Dosage __________
4) ______________________________ Dosage __________
5) ______________________________ Dosage __________

Allergy: Use back for additional allergies.

	Reactions (Check One)			Symptoms
1) ____________	☐ Mild	☐ Moderate	☐ Severe	____________
2) ____________	☐ Mild	☐ Moderate	☐ Severe	____________
3) ____________	☐ Mild	☐ Moderate	☐ Severe	____________
4) ____________	☐ Mild	☐ Moderate	☐ Severe	____________

Social History:

Occupation: ______________________________

Do you smoke? ☐ Yes ☐ No Amount ______________

Do you drink alcohol? ☐ Yes ☐ No Amount ______________

Do you use recreational drugs? ☐ Yes ☐ No Amount ______________

Family History:

Please list any family history (mother, father, grandparent, sister, brother, aunt, uncle, cousin, niece, nephew) who has or has had any of the listed forms of cancer.

☐ I was adopted ☐ No known family history

Relationship to You	Mother's Side or Father's side	Type of Cancer	Approximate Age of Diagnosis
	☐ M ☐ F	☐ Breast ☐ Ovarian ☐ Colon ☐ Pancreatic ☐ Melanoma	
	☐ M ☐ F	☐ Breast ☐ Ovarian ☐ Colon ☐ Pancreatic ☐ Melanoma	
	☐ M ☐ F	☐ Breast ☐ Ovarian ☐ Colon ☐ Pancreatic ☐ Melanoma	
	☐ M ☐ F	☐ Breast ☐ Ovarian ☐ Colon ☐ Pancreatic ☐ Melanoma	
	☐ M ☐ F	☐ Breast ☐ Ovarian ☐ Colon ☐ Pancreatic ☐ Melanoma	

Other Family Conditions:

☐ High Blood Pressure ______________ ☐ Diabetes ______________

☐ Stroke ______________ ☐ Heart Disease ______________

Patient Name: ______________ DOB: ______________ Today's Date ______________

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Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Referring Physician(s): ______________________
Date of Last Mammogram:______________ Location (What Facility?): __________
Date of Last Breast Ultrasound: ______________ Location (What Facility?): __________

Current Problem(s)/Concern(s): mark all that apply.
Which Breast: ☐ Left ☐ Right ☐ Both ☐ New Cancer Diagnosis
☐ Abnormal Imaging ☐ Pain ☐ Nipple Discharge ☐ 2nd Opinion ☐ Lump ☐ Skin Changes
When did you notice this?______________ By whom? __________
Has it Changed? ☐ No ☐ Yes How? __________
Does it vary with your natural menstrual cycle? ☐ No ☐ Yes How? __________
Have you had a biopsy for this? ☐ No ☐ Yes Results? __________

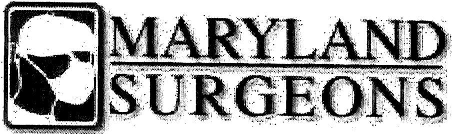
Do you perform self breast exams? ☐ No ☐ Yes How Often? __________
Have you had breast cancer or any cancer in the past? ☐ No ☐ Yes When? __________
Was it invasive? ☐ No ☐ Yes ☐ Don't know
Treatment: __________
Chemotherapy? ☐ No ☐ Yes Radiation? ☐ No ☐ Yes
Have you ever taken: ☐ Tamoxifen ☐ Arimidex ☐ Remara ☐ Other Anti Estrogens __________
How long did you take or have you been taking the above medications?__________

Age when you started menstrual periods ________ years old.
Age at first live birth __________ years old. Number of Pregnancies __________
Are you currently breast feeding? ☐ No ☐ Yes Number of Deliveries __________
Have you breastfed in the last 6 months? ☐ No ☐ Yes

Do you still have periods? ☐ Yes Start date last menses __________
☐ No Age at Menopause? __________
☐ Natural ☐ Surgical ☐ Chemo ☐ Birth Control Induced
☐ Ovaries Removed: ☐ One ☐ Both
☐ Hysterectomy, reason for __________
Have you ever taken birth control pills? ☐ No ☐ Yes
How Long? Start (month/year): __________ Stopped (month/Year): __________
Have you ever taken fertility drugs? ☐ No ☐ Yes When? __________ How Long?__________
Have you ever taken hormone replacement therapy (estrogen/progesterone)? ☐ No ☐ Yes
What type of hormone replacement? __________
How Long? Start (month/year): __________ Stopped (month/year):__________

Have you ever had genetic testing for breast or ovarian cancer? ☐ No ☐ Yes
Results:

Patient Name:______________________DOB: ______________Today's Date__________



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

If not, policyholder's name? ___________________

Policyholder Date of Birth ____________________

(*this information is NOT on the card*)

Relationship to Patient ____________

Policyholder Employer ____________

Secondary Insurance ______________________

Are you the policyholder? _____Yes ____No

If not, policyholder's name? ___________________

Policyholder Date of Birth ____________________

Relationship to Patient ____________

Policyholder Employer ____________

Other Health Care Providers

GYN Name________________________Phone ______________Fax__________

Gastroenterologist ____________________Phone______________Fax__________

Oncologist ________________________Phone______________Fax__________

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:**__________________________