

# Patient Registration Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Current Bra Size: \_\_\_\_\_  
Referred By: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

## Yes or No

Y N Can you feel lumps in your breast now? How and when did you discover this?  
\_\_\_\_\_

Y N Have you had a mammogram previously?  
Where? \_\_\_\_\_ When? \_\_\_\_\_

Y N Have you previously had a Bone Density test performed? If so, When? \_\_\_\_\_

Y N Have you had any nipple discharge? If so which nipple? Right or Left \_\_\_\_\_

Y N Have you experienced pain, discomfort, or soreness?  
If so, how long? \_\_\_\_\_

Y N Have you had any injury to the area?  
If so, when and how? \_\_\_\_\_

Y N Previous breast surgery? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

Y N Aspiration with needle? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

Y N Biopsy? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

Y N Mastectomy? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

Y N Breast Implant? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

### **Are your implants Silicone / Saline ?**

Y N Breast Reduction? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

Y N Lumpectomy for Cancer? Right \_\_\_ Left \_\_\_ When: \_\_\_\_\_ Physician: \_\_\_\_\_

## Y N **Family History of Breast, Ovarian, Uterine, Prostate, Colon Cancer, or Melanoma?**

	<u>Who?</u>	<u>Age at diagnosis?</u>	<u>Type of Cancer</u>
<input type="checkbox"/>	Self	_____	_____
<input type="checkbox"/>	Grandmother	_____	_____
<input type="checkbox"/>	Mother	_____	_____
<input type="checkbox"/>	Sister	_____	_____
<input type="checkbox"/>	Aunt	_____	_____
<input type="checkbox"/>	Daughter	_____	_____
<input type="checkbox"/>	Father	_____	_____

Y N DO YOU PRACTICE SELF EXAMS? If yes, how often? \_\_\_\_\_

### **Menstrual History**

Y N Do you menstruate? Age at first period \_\_\_ Beginning date of last period: \_\_\_\_\_

Y N If you do not menstruate, approximate date of your last period: \_\_\_\_\_

Y N Have you had a hysterectomy? If yes, when? \_\_\_\_\_ Why? \_\_\_\_\_

Y N Have your ovaries been removed? If yes, when? \_\_\_\_\_ Why? \_\_\_\_\_

Y N Is there a possibility you are pregnant?

**Hormone History** (birth control pills, estrogen, progesterone, thyroid, or cortisone)  
Y N Have you ever taken any form of the hormones listed above?  
If yes, which type, how long have you taken it, and date of last dose:\_\_\_\_\_

Y N Do you have any biological children?  
How many pregnancies have you had?\_\_\_\_\_ Live Births:\_\_\_\_\_

Age at first pregnancy:\_\_\_\_\_ Age at last pregnancy:\_\_\_\_\_

Y N Did you breast feed? If yes, how long with each child?\_\_\_\_\_

**Medical History**  
Y N Do you have any drug allergies? Please list ALL allergies and your reactions  
Please also include allergies to adhesives, latex, soaps, etc.):\_\_\_\_\_

Y N Do you have history of Tuberculosis (TB)?

Y N Have you had any other surgeries besides the breasts? Please list when and why:

Y N Have you ever had problems with anesthesia? Please Explain:\_\_\_\_\_

Y N Do you need to take antibiotics prior to surgery or dental procedures? Why:

Y N Do you have any chronic conditions? If yes, **please circle** all that apply:  
Diabetes Type\_\_\_, Heart Condition, Bleeding Disorder, Asthma,  
High Blood Pressure, Mitral Valve Prolapse, Sleep Apnea, etc.  
Please explain:\_\_\_\_\_

Y N Have you EVER been diagnosed with ANY communicable disease  
(**HIV, Hepatitis C**, etc.)? If so, what ?\_\_\_\_\_

Y N Do you require the use of an insulin pump?

Y N Do you require the use of a C-Pap machine?

Y N Do you have a pacemaker? If so, what is the contact number on your  
card in case of diagnostic procedure interference?\_\_\_\_\_

**Social History**  
Y N Do you smoke or have you ever smoked? If yes, how much daily:\_\_\_\_\_

How many years have been a smoker?\_\_\_\_\_

Y N Do you drink alcohol? If yes, how often?\_\_\_\_\_

Y N Do you drink caffeinated drinks or eat chocolate? How much daily?  
Coffee:\_\_\_\_\_ Tea:\_\_\_\_\_ Soft Drinks:\_\_\_\_\_ Chocolate:\_\_\_\_\_



**Patient Information**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ COUNTY \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME # \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

E-MAIL \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SPOUSE SSN \_\_\_\_\_

SPOUSE \_\_\_\_\_ SPOUSE DOB \_\_\_\_\_

CELL PHONE \_\_\_\_\_ WORK \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ DEDUCTABLE \_\_\_\_\_

POLICY/I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ CARD HOLDER \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ DEDUCTABLE \_\_\_\_\_

POLICY/I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ CARD HOLDER \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I understand I am responsible for all fees, regardless of insurance coverage which may include co-pays, deductibles, or co-insurance. I assign insurance payments directly to the doctor. I authorize the office to release all information necessary to secure the payment of benefits of insurance. This authorization renews annually.

I authorize the Breast Care Center of Indiana, P.C. to obtain any available pathology slides, x-ray films, and reports of my medical care.

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
SIGNATUE OF INSURED IF OTHER THAN PATIENT

\_\_\_\_\_  
DATE