The GW Medical Faculty Associates

BREAST CARE CENTER

NEW PATIENT INFORMATION FORM

Name: _____ Age: ____ Cell phone #: _____
(first, middle initial, last)

Email: _____Preferred method of contact:_____

Referring Physician: _____ Primary Care Physician: _____

Name of other physician(s) to whom you want reports sent: _____

How did you learn about the Breast Care Center?
☐My doctor referred me ☐ Referred by a friend ☐ Radio ad ☐Other: _____

Reason for your visit: _____

HEALTH HISTORY

Please list all surgeries you have had and the date of those surgeries: _____

_____

Please complete the following or write "n/a" *(not applicable)*:

First day of most recent menstrual period: _____ Age of first period: _____ Age of menopause: _____

Total number of pregnancies: _____ Total number of births: _____How old were you when you had your first baby? _____

Did you breastfeed/how long? _____Have you ever taken hormone replacement therapy? _____

Have you ever been told you have: (check all that apply):

☐ Bleeding tendency
☐ Depression/anxiety disorder
☐ Diabetes
☐ AIDS/HIV
☐ Heart attack/angina
☐ High blood pressure
☐ Asthma/emphysema
☐ Hepatitis
☐ Heart murmur: Do you require prophylactic antibiotics before dental or surgical procedures? ☐ Yes ☐ No
☐ Any other medical problems:
_____
_____
_____
_____

MEDICATIONS

List (or attach list) of all medications (including vitamins, herbal supplements, aspirin and other over-the-counter medications)

_____

ALLERGIES (please include allergies to medications as well as environmental & the type of reaction you have)

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Previous smoker? ☐ Yes ☐ No When did you quit? _____
Do you consume alcohol? ☐ Yes ☐ No How many drinks? *(please circle)* 1 2 3 4 5+ per day / week

FAMILY HISTORY

List any immediate family members who have had breast or ovarian cancer and their age at diagnosis:

_____
_____
_____

Do you have any other relatives with cancer? ☐ Yes ☐ No Please list relationship and type of cancer:

_____
_____

TESTS

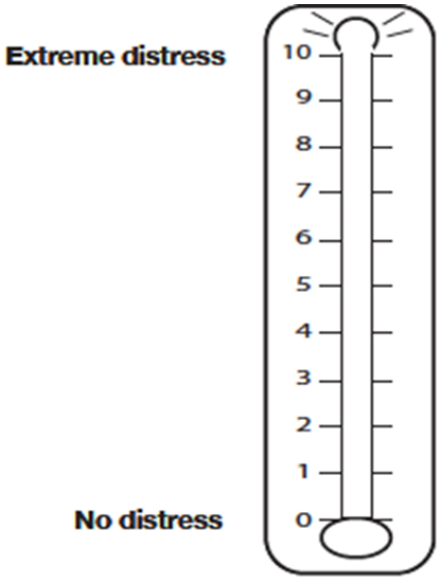
Date of last Mammogram:_____ Date and type of Additional Imaging:_____
Date of Biopsy:_____ Location of Films:_____
Films Scanned: ☐ Yes ☐ No Films Returned to Patient: ☐ Yes ☐ No

If you have ever been told that you have breast cancer or would like more information about our services refer to next page. Please note, we request 24 hours cancellation notice for future appointments.

Distress Screening Questionnaire

If you have recently been told you have cancer, please fill out the following form. A member of our team will be in contact with you if we believe you might benefit from additional services.

Instructions: First, please circle the number that best describes how much distress you have been experiencing in the past week including



Second, please indicate if any of the items to the right has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	**Practical Problems**
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

YES	NO	**Physical Problems**
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/Concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

❑ ❑ **Spiritual/Religious Concerns**

Other Problems:_____

Please write your email address here if you would like to be sent our monthly calendar of support programs:

_____