Hackensack Meridian *Health*
Hackensack University Medical Center

Patient Name	MRN

SURGICAL BREAST PRACTICE
NEW PATIENT QUESTIONNAIRE

DATE:_____

Date of birth _____ Age _____

REASON FOR VISIT

Abnormal Mammogram R L please specify _____
Lump/Thickening R L upper lower inner outer
Pain R L upper lower inner outer on palpation w/periods
Nipple Discharge R L spontaneous nonspontaneous color_____ frequency _____
Infection R L red skin lump drainage please specify _____
New Breast Cancer R L please specify _____
Risk Evaluation _____
Second Opinion _____
Other _____

Do you perform monthly breast exams? Y N

RISK ASSESSMENT

Have you ever had a breast biopsy? Y N

Type

Needle Biopsy	R	L	Both	Year _____
Surgical Biopsy	R	L	Both	Year _____

Do you have a personal history of breast cancer? Y* N

***If yes, please fill out the following questions:**

What type of surgery did you have?

Mastectomy	R L	Both	Date _____	Where _____
Lumpectomy	R L	Both	Date _____	Where _____
Sentinel node biopsy	R L	Both	Number of nodes positive _____	
Axillary node dissection	R L	Both	Number of nodes positive _____	

Did you have breast reconstruction? Y N Type_____

Did you have chemotherapy? Y N Type_____

Did you have radiation? Y N Dates_____

Did you take:

Tamoxifen	Y	N	Dates _____
Arimidex	Y	N	Dates _____
Femara	Y	N	Dates _____
Other	Y	N	Dates _____

PAST MEDICAL HISTORY

Currently or in the past, have you had any of the medical issues below? **Please indicate if yes.**

___ Atrial Fibrillation
___ Anesthesia Problems
___ Arthritis/Osteoarthritis
___ Asthma
___ Bleeding/Clotting Disorder
    ___ Pulmonary Embolism
    ___ DVT
___ Diabetes Mellitus
___ COPD/Emphysema
___ Epilepsy
___ Heart Attack
___ Heart Failure
___ HIV
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Thyroid Disease
    ___ Hypothyroidism
    ___ Hyperthyroidism
___ High Cholesterol
___ Hypertension
___ Kidney Disease
___ Liver Disease
___ Lupus
___ Migraines
___ Peptic Ulcer Disease
___ GERD
___ Scleroderma
___ Stroke ___ TIA
___ Sleep Apnea ___ on CPAP
___ Rheumatoid Arthritis
___ Other _____

Comments: _____
_____
_____

PAST SURGICAL HISTORY

TYPE OF SURGERY	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION	DOSE	ALLERGIES	REACTION
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

FAMILY HISTORY

Do you have a family history of breast or ovarian cancer? Y N Unknown (if Yes, answer below)

Relation (Maternal)	Breast Cancer	Ovarian Cancer	Age at Diagnosis	Age Now	Age when deceased
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Relation (Paternal)	Breast Cancer	Ovarian Cancer	Age at Diagnosis	Age Now	Age when deceased
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other cancers in your family? (please specify type of cancer and family member)

_____

Are your ancestors Ashkenazi Jewish? Y N

Have you or a family member undergone gene testing for breast cancer mutations? Y N

Do you have a personal history of any other type of cancer? Y N
Type _____
Treatment _____

MENSTRUAL HISTORY

Age at first period _____
Number of pregnancies _____ Number of live births _____
Age at first delivery _____
Total times you breast fed _____
Menstrual cycles Regular _____ Irregular _____ Date of last period _____
Age at menopause _____
Have you had a hysterectomy? Y N Reason _____
Were your ovaries removed? Y N

HORMONE HISTORY

Have you ever taken birth control pills? Y N

Currently _____ Previously _____ at what age _____ how long _____

Have you ever had infertility treatments? Y N Number of cycles _____

Have you ever taken hormone replacement? Y N

Currently _____ Previously _____ at what age _____ how long _____

GENERAL RISK QUESTIONS

Do you smoke cigarettes? Y N packs per day _____ how many years _____

Did you ever smoke cigarettes? Y N packs per day _____ how many years _____ age you quit _____

Do you drink alcohol? Y N how many per day: Beer _____ Wine _____ Liquor _____

Have you ever used drugs? Y N Marijuana _____ Heroin _____ Cocaine _____ Other _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Occupation: _____

REVIEW OF SYSTEMS: ******PLEASE ANSWER ALL QUESTIONS******

CONSTITUTIONAL

Fever	YES	NO
Chills	YES	NO
Weight loss	YES	NO
Malaise/fatigue	YES	NO
Sweating	YES	NO
Weakness	YES	NO

EYES

Blurred vision	YES	NO
Double vision	YES	NO
Light sensitivity	YES	NO
Eye pain	YES	NO
Eye discharge	YES	NO
Eye redness	YES	NO

SKIN

Rash	YES	NO
Itching	YES	NO

ENDO/HEME/ALLERGIES

Easy bruise/bleed	YES	NO
Environment allergies	YES	NO
Frequent thirst	YES	NO

HEAD AND NECK

Headaches	YES	NO
Hearing loss	YES	NO
Ear ringing	YES	NO
Ear pain	YES	NO
Ear discharge	YES	NO
Nosebleeds	YES	NO
Congestion	YES	NO
Sore throat	YES	NO

GASTROINTESTINAL

Heartburn	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Abdominal pain	YES	NO
Diarrhea	YES	NO
Constipation	YES	NO
Blood in stool	YES	NO

CARDIOVASCULAR

Chest pain	YES	NO
Palpitations	YES	NO
Shortness of breath when laying down	YES	NO
Leg pain with walking	YES	NO
Leg swelling	YES	NO

RESPIRATORY

Cough	YES	NO
Hemoptysis (coughing up blood)	YES	NO
Sputum production	YES	NO
Shortness of breath	YES	NO
Wheezing	YES	NO

GENITOURINARY

Painful urination	YES	NO
Urgency	YES	NO
Frequency	YES	NO
Blood in urine	YES	NO
Flank pain	YES	NO

MUSCULOSKELETAL

Muscle pain	YES	NO
Neck pain	YES	NO
Back pain	YES	NO
Joint pain	YES	NO
Falls	YES	NO

NEUROLOGICAL

Dizziness	YES	NO
Tingling	YES	NO
Tremor	YES	NO
Sensory change	YES	NO
Speech change	YES	NO
Focal weakness	YES	NO
Seizures	YES	NO
Loss of consciousness	YES	NO

PSYCHIATRIC

Depression	YES	NO
Suicidal ideas	YES	NO
Substance abuse	YES	NO
Hallucinations	YES	NO
Nervous/anxious	YES	NO
Insomnia	YES	NO
Memory loss	YES	NO

PATIENT CONTACT INFORMATION AND REFERRING PHYSICIANS

Please supply your contact information and indicate which number should be used as the primary contact number.

PATIENT NAME: _____

Home phone: _____
Primary contact number Y N May we leave a message Y N

Work phone: _____
Primary contact number Y N May we leave a message Y N

Cell phone: _____
Primary contact number Y N May we leave a message Y N

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

Is it okay to discuss care with this person? Y N

PHYSICIAN INFORMATION

Please complete so we can provide your physician with information regarding your visit.

Medical Doctor	Gynecologist
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

I, _____, do hereby request and authorize The Surgical Breast Practice at Hackensack University Medical Center, Hackensack, New Jersey to obtain medical information concerning myself.

_____

(Relationship)

In the form of original breast imaging and/or slides (if applicable) along with reports performed at your institution.

DATE OF SERVICE: _____

I further understand that this authorization is limited to the above request.

_____ _____

(Patient's Signature) (Patient's Date of Birth)

_____

(Date)

Please fax reports to the following number:

Fax number: (551) 996-0980, Attention: Christine Moriarty

If you need to telephone Christine Moriarty, please call (551) 996-5689.

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If you are mailing films or slides, please mail them to this address:

Surgical Breast Practice
Attention: Christine Moriarty
20 Prospect Ave, Suite 402
Hackensack, NJ 07601