KAREN S. BARBOSA, D.O.
BOARD CERTIFIED,
FELLOWSHIP TRAINED
BREAST SURGEON

TOP TIER
Medical Breast Specialist, P.C.

80 MAPLE AVENUE
SMITHTOWN, NY 11787

OFFICE: 631.870.8721
FAX: 631.870.8722

## Office Visit Information Page1

Welcome to Top Tier Medical Breast Specialist, P.C. In order to facilitate your visit today, please take a few moments to complete the form below and list any questions you would like addressed.

**Name** _____ **Nickname** _____ **Birth date** _____

**Age** _____ **Race** _____ **Height** _____ **Weight** _____

**Occupation** _____ **Appointment date** _____

**How did you come to Dr. Barbosa's practice?**

☐ Self referral ☐ Friend
☐ Physician _____ ☐ Other referral source _____

**What brings you to the office today?** _____

_____

Primary care physician _____ OB/GYN _____

**Are you currently experiencing any of the following?** (please check all that applies)

| | | | |
|---|---|---|---|
| Abnormal mammogram: | ☐ Right | ☐ Left | ☐ Both |
| Breast lump: | ☐ Right | ☐ Left | ☐ Both |
| Lump under arm: | ☐ Right | ☐ Left | ☐ Both |
| Nipple Discharge: | ☐ Right | ☐ Left | ☐ Both |
| Breast pain: | ☐ Right | ☐ Left | ☐ Both |

Please rate your pain on a scale of 1-10 (where 10 is the worst) _____

**How do you monitor your breast health?**

☐ A physician examines my breasts every year
☐ I have had a Breast MRI Date _____
☐ I examine my breasts ☐ Monthly ☐ Occasionally ☐ Never

**Do you experience any of the following currently or occasionally?** (please check)

| | | | |
|---|---|---|---|
| ☐ Glasses | ☐ CHF | ☐ IBF | ☐ Easy bruising |
| ☐ Hearing aid | ☐ Pacemaker | ☐ Ulcers | ☐ Fatigue |
| ☐ False teeth | ☐ Cough | ☐ Bloating | ☐ Blood in sputum |
| ☐ Difficulty swallowing | ☐ Shortness of breath | ☐ Change in stool | ☐ Vaginal spotting or bleeding |
| ☐ Sinusitis | ☐ Asthma | ☐ OA | ☐ Tender/enlarged lymph nodes |
| ☐ Palpitations | ☐ Pneumonia | ☐ RA | ☐ Dizziness |
| ☐ Chest pain | ☐ Bronchitis | ☐ ROM restrict | ☐ Night sweats |
| ☐ Afb | ☐ Lack of appetite | ☐ Ringing in ears | ☐ Menstrual irregularities |
| ☐ Arrhythmia | ☐ Abdominal pain | ☐ Hot flashes | ☐ Change in weight |
| ☐ Murmur | ☐ Reflux | | |

Patient Name:

**Have you had in the past? (please check all that applies)**

☐ Breast Biopsies Year _____ ☐ Right ☐ Left ☐ Both
Year _____ ☐ Right ☐ Left ☐ Both
Year _____ ☐ Right ☐ Left ☐ Both

Did a biopsy ever show atypical ductal hyperplasia (ADH)? ☐ Yes ☐ No
Did a biopsy ever show atypical lobular hyperplasia (ALH)? ☐ Yes ☐ No

☐ Breast Cyst Year _____ ☐ Right ☐ Left ☐ Both

☐ Breast Implants Year _____ Which type? ☐ Saline ☐ Silicone ☐ Combination

☐ Breast Reduction Year _____

☐ Breast Cancer Year _____ ☐ Right ☐ Left ☐ Both

How was it treated?

☐ Lumpectomy ☐ Mastectomy By whom? _____
☐ Breast reconstruction By whom? _____
What type? _____ Year _____
☐ Radiation By whom? _____
☐ Chemotherapy By whom? _____
☐ Anti-estrogen pills By whom? _____
(e.g. Tamoxifen, Armidex, Femara)

**Have you had any other type of cancer?** ☐ Yes ☐ No
What type _____ Year _____
Did you receive radiation? ☐ Yes ☐ No
Did you receive chemotherapy? ☐ Yes ☐ No

**Regarding your general health, have you had, or are you being treated for:**

☐ High blood pressure
☐ Increased cholesterol
☐ CHF
☐ Bronchitis/pneumonia
☐ Reflux
☐ Liver disease
☐ Arthritis, rheumatoid or osteoporosis
☐ Blood clots
☐ Depression
☐ Diabetes
☐ Heart attack
☐ Atrial fibrillation/arrhythmia
☐ Asthma
☐ Ulcers
☐ Kidney disease
☐ Rom restriction
☐ Stroke
☐ Anxiety
☐ Glasses
☐ Sinuses
☐ Murmur
☐ Pacemaker
☐ IBS

Please list any others:

**Have you had any (other type of) surgery?** (please use the back if necessary)

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

Patient Name:

**Please list all medications** (please use the back if necessary)

Medication Dose Route Frequency

_____

_____

_____

_____

**Do you take any herbal supplements?** Please list _____

**Do you take** ☐ Multi-vitamin ☐ Calcium ☐ Vitamin D ☐ Omega-3

**Are you allergic to any medications?** ☐ Yes ☐ No

If yes, please list: _____ Reaction: _____

_____ Reaction: _____

Do you have a latex allergy? ☐ Yes ☐ No

**For Womem Only**

Age when menstrul cycle began (usually 12-13) _____

Date of last mensus _____

Age at first live birth _____

Number of pregnancies _____ Number of children born _____

Did you breast feed? ☐ Yes ☐ No For how long? _____

Age at menopause _____

Do you still have your uterus? ☐ Yes ☐ No

Do you still have your ovaries? ☐ Yes ☐ No

**Are you currently taking or have you ever taken any of the following hormonal medications?**

☐ Birth control pills Duration _____ Side Effects _____

☐ Estrogen Duration _____ Side Effects _____

☐ Progesterone Duration _____ Side Effects _____

☐ Combination Duration _____ Side Effects _____

☐ Other: Duration _____ Side Effects _____

**Are you of Ashkenazi Jewish ancestry?** ☐ Yes ☐ No

**Has any blood relatives had breast cancer?** ☐ Yes ☐ No **(If yes, please list specific information below)**

| Relationship | Maternal | Paternal | Age at diagnosis | One of both breasts affected | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Patient Name:

**Has any blood relative had ovarian cancer?** Yes No (If yes, please list specific information below)

| Relationship | Maternal | Paternal | Age at diagnosis | Treatment received / Current status of relative |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Has any blood relative had any other type of cancer?**
(if yes, please list specific type of cancer below, e.g. prostate, colon, uterine, pancreatic, melanoma, sarcoma, brain, lung, thyroid, or leukemia)

| Relationship | Maternal | Paternal | Age at diagnosis | Type of cancer | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Has any blood relative had osteoporosis, stroke, heart attacks, blood clots, or thyroid disease?**

| Relationship | Maternal | Paternal | Age at diagnosis | Diagnosis | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Have you ever smoked?** ☐ Yes ☐ No

If yes, please indicate how many packs per day, and how many years you smoked:

PPD _____ Years _____

Are you currently smoking? ☐ Yes ☐ No When did you quit? _____

**Do you drink alcohol?** ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Never

**Do you eat or drink foods or beverages containing caffeine?** (e.g., coffee, tea, chocolate) ☐ Yes ☐ No

If yes, please list which and average daily consumption: _____

**How would you rate your stress level?**

☐ Extreme ☐ Moderate ☐ Minimal

**Do you exercise?**

☐ Never ☐ Sometimes ☐ 30 minutes 5 times a week or more

**Questions you would like answered at your visit:**

1. _____
2. _____
3. _____

**Thank you! We are looking forward to meeting you.**

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## New Patient Intake Sheet

Patient Name _____ Date of Birth _____ Sex ☐ M ☐ F

Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone #(s) Home _____ Work _____ Mobile _____

Emergency Contact _____

Phone _____ Relationship _____

**Primary Insurance**

Name of Insurance _____ ID# _____ Group# _____

Mailing Address _____

Policyholder _____ Date of Birth _____ Social Security # _____

Relationship to Patient _____ Insured's Employer _____

**Secondary Insurance**

Name of Insurance _____ ID# _____ Group# _____

Mailing Address _____

Policyholder _____ Date of Birth _____ Social Security # _____

Relationship to Patient _____

**Primary Care Doctor** _____ Phone _____

Address _____

**Referring Physician** _____ Phone _____

Address _____

**Reason for Visit** _____

All professional services rendered are charges to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also requested that you pay for services when rendered unless other arrangements have been made in advance with one of our account managers.

**Insurance Authorization and Assignment:**

I hereby authorize TOP TIER MEDICAL BREAST SPECIALIST, P.C. to furnish information to insurance carriers concerning my treatment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the provider if assignment of benefits applies.

Signature: _____ Date: _____

**General Consent For Treatment:**

I, the undersigned, do hereby agree and give consent for admission/treatment to TOP TIER MEDICAL BREAST SPECIALIST, P.C. I hereby request and authorize the above Medical Center, the Physicians on its medical staff, the members of the staff and nursing staff, assisted by the employees of the Center, to provide such care and administer such diagnostic, radiological and/or therapeutic procedures and treatment as, in the judgment of the Physician, is deemed necessary or advisable in this patient's care. This includes all routine diagnostic tests and procedures. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments or examinations done in the Medical Center.

Signature: _____ Date: _____

**TOP TIER MEDICAL BREAST SPECIALIST, P.C.**
**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital information. I also acknowledge and understand that I may request copies of separate notices explain special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____

Signature of Patient/Personal Representative

_____

Print Name of Patient/Personal Representative Date

_____

Description of Personal Representative Authority

_____

Top Tier Medical Breast Specialist, P.C. Representative's Signature Date

_____

Please Print Name