The Hoffberger Breast Center at Mercy
Weinberg 5th Floor
227 St. Paul Place
Baltimore MD 21202-2001
Phone: 410-332-9330
Fax: 410-347-1175

REGISTRATION INFORMATION

Patient Name: ______________________________ DOB: __________ Age: _____________
Address: ______________________________ Sex: __________ Preferred Language:______________
______________________________ Email: ____________________________

Telephone Information:
Home Phone: _________________________
Work Phone: _________________________

Telephone Information:
Mobile: ________________________

Extended Emergency Contact Information
Primary Emergency Contact:
Address:
Home Phone:
Relation:

Primary Insurance

Plan	Subscriber Name & DOB	Relationship	Member #	Group #

Referral Information
Referred by:____
Reason for Referral:
____

Send copy of notes to:
Dr. ____ Phone#: ____________________
Address: ____ Zip Code: ____________________
Dr. ____ Phone#: ____________________
Address: ____ Zip Code: ____________________

AMBULATORY CARE RECORD
PATIENT SUMMARY

Patient Name: ______________________ **Age:** ________ **DOB:** ___________

Problem for which you are being seen:
____
____

When was the problem first noticed: ____________ **Location in breast:**_____________
Have you felt any breast lumps? ________ **Any nipple discharge:** _____________
Have you ever had breast surgery? ________ **Any needle biopsies?**____________

Family history of breast cancer (please list relationship and age at diagnosis):
____
____

Family history of ovarian cancer (please list relationship and age at diagnosis):
____
____

Reproductive History:

Age of first menstrual cycle ______ Age at first full term Pregnancy ____

# of Pregnancies ____ # of Children ____ # of Miscarriages ____ # of Abortions ____

Last Menstrual Period: ___________ Hysterectomy: Yes / No If yes, at what age? ____

Circle Type: Abdominal/Vaginal/Laparoscopic/Robotic

Removal of Ovaries: Yes / No If yes, one or both? ______ At what age? _____

History of Birth control pill use: Yes / No How many years ___ Current Use: Yes / No

History of Hormone Replacement Therapy: Yes / No How many years ____ Current Use: Yes / No

History of Fertility Treatment: Yes / No

Medical Problems: Circle all that apply

High Blood Pressure	Asthma	Blood Clot (DVT)	Anemia	Excessive Bleeding
Heart Attack	Emphysema	Pulmonary Embolism	Arthritis	Depression/Anxiety
Heart Problems	TB	Reflux (GERD)	Osteoporosis	Autoimmune Disorder
High Cholestrol	HIV or AIDS	Hiatal Hernia	Osteopenia	Thyroid Disease
Stroke	Kidney Disease	Stomach Ulcers	Seizures	Alzheimer's disease
Diabetes	Thyroid Disease	Hepatitis or Jaundice	Migraines	Anesthesia problems

Other - Please list: ____

Cancer - What kind?
____

Patient Name: ______________________ **Age:** ________ **DOB:** ___________

Previous surgical procedures: List with year of surgery

____
____
____
____

Medications: List drug, dose and how often

Aspirin: Y / N _____________________ Blood Thinners: Y / N____________________

Other:____
____
____
____
____
____

Drug Allergies: List drug and reaction

____
____
____

Latex Allergy: Y / N **Adhesives:** Y / N

Family History:

Mother: If Alive Age: _____

If Deceased: Age at Death: _____ Cause of Death: ________________________

Medical problems:____
____

Father: If Alive Age: _____

If Deceased Age at Death: _____ Cause of Death:________________________

Medical problems:____
____

How many siblings (both living and deceased)?

# of Brothers _____ Medical Problems___________________________________
____

# of Sisters _____ Medical Problems___________________________________
____

Personal History:

Single/ Married / Widow / Divorced Who lives with you:_________________

Employment: Homemaker / Retired / Work Nature of work:____________________

Smoking History:

Have you ever smoked? Yes / No If Yes, do you smoke currently? Yes / No

Maximum # of packs/day smoked: ____ # of packs/day currently smoked: ____

How many years have you smoked? ____ Have you quit? Yes / No

When did you quit? _______

Patient Name: ______________________ **Age:** ________ **DOB:** ___________

Alcohol Use:

Yes / No # of drinks/week ____

Review of systems: <u>Recently</u> (within 30 days) experienced any of the following list of problems <u>(please circle all applicable)</u>

General:	Fever Fatigue Weight loss Weight gain Night Sweats Hot Flashes
Neurological:	Headache Weakness Numbness Fainting Seizures Memory Loss
Cardiac:	Palpitations Chest pain Feet swelling Shortness of breath laying flat
Respiratory:	Cough Sinus problems Shortness of breath
Abdominal:	Stomach pain Nausea Vomiting Blood in stool Constipation Diarrhea No appetite Heartburn
Urinary:	Difficulty passing urine Pain with urination Frequent urination Blood in urine Urinary tract infection
GYN:	Spotting Vaginal discharge Irregular periods Vaginal dryness Painful intercourse
Musculoskeletal	Back pain Arthritis Aches & Pains
Psychiatric:	Depression Anxiety Suicidal thoughts
Other:	Increased thirst Tremors Swollen glands Feeling excessively hot/cold Lymphedema (arm/hand swelling)

Signature of Patient____**Date**________________