St. Luke's Roosevelt

University Hospital of
Columbia University College
of Physicians & Surgeons

St. Luke's Hospital
Breast Services

Continuum Health Partners, Inc.

Patient Information

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email Address: _____

Date of Birth: _____/_____/_____ Age: _____Sex: ____ SS:_____
(Office use Only)

Occupation: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Confidential Health Questionnaire

Reason for the consult? (Please be specific): _____

_____

Referral

Name, address of referral doctor and/or medical doctor

_____

_____

_____

Breast History

When was your last mammogram and where? _____

Do you have a history of the following?

- ☐ Breast Cancer
- ☐ Breast atypia
- ☐ Previous breast biopsy
- ☐ Breast swelling
- ☐ Nipple discharge
- ☐ Breast pain
- ☐ Cyst aspiration

Other: _____

_____

_____

GYN History

1. ☐ Hysterectomy ☐ Oophorectomy

2. Age at your first menstrual period: _____When your last period: _____

3. How many total pregnancies have you had total? _____

4. Live Births: ____ Abortions? _____ Miscarriages? _____

5. Age at your first delivery? _____

6. Did you breast feed? _____ If so, for how long total? _____

Hormonal Use

Have you ever taken the following? Please indicate the type, when and how long.
Birth control: _____
Hormone replacement therapy _____
Fertility drugs _____

Current Meds & Doses (including prescription, non-prescription(s), & herbals)

_____

_____

_____

Allergies (including drugs, foods, adhesives and IV contrast dyes)

_____

_____

List Previous Medical Conditions

_____

_____

_____

_____

List Previous Surgeries

_____

_____

_____

Social History

Substance Usage:

Tobacco: ☐ Cigarettes _____ packs/day / Stopped date _____
☐ Cigars ☐ Pipe ☐ Snuff

Alcohol: ☐ Beer ☐ Liquor ☐ Wine : _____/Day
Stopped Date: _____

Caffeine: ◯ Coffee ◯ Tea ◯ Cola

Drugs: _____

Family History

Please list family history of diseases, cancers specifically breast or ovarian cancers.

Mother	_____	Grandmother	_____	Grandfather	_____
Father	_____	Grandmother	_____	Grandfather	_____
Son	_____	Aunts	_____		
Daughter	_____	Uncles	_____		
Brother	_____	Others	_____		
Sister	_____				

Review of Systems

1. Constitutional
☐ Weight Loss ☐ Weight Gain
☐ Loss of Appetite ☐ Fever
☐ Unusual Weakness ☐ Night Sweats

2. Eyes/Ears/Nose
☐ Recent Visual Change
☐ Double Vision ☐ Hearing Loss
☐ Ringing in Ears ☐ Nose Bleeds

3. Mouth/Throat
☐ Ulcers ☐ Thyroid Problems
☐ Gum Bleeding/Pain ☐ Hoarseness
☐ Difficulty Swallowing

4. Respiratory
☐ Asthma ☐ Chest Pain
☐ Shortness of Breath ☐ Wheezing
☐ Cough ☐ Pleurisy
☐ History Pneumonia/Bronchitis

5. Cardiac
☐ High Blood Pressure ☐ Palpitations
☐ Chest Pain (angina) ☐ Leg/Foot Edema
☐ Shortness of Breath ☐ Aneurysm
☐ History of Heart Attack
☐ Murmur ☐ Heart Failure

6. GI
☐ Nausea ☐ Vomiting
☐ Pain ☐ Colitis
☐ Diarrhea ☐ Constipation
☐ Blood in Stool ☐ Ulcer
☐ Change Bowel Habits ☐ Vomiting Blood
☐ Hemorrhoids ☐ Hepatitis

7. Genitourinary
☐ Frequent Urination
☐ Incontinence of Urine/Stool
☐ Burning on Urination ☐ Blood in Urine
☐ Kidney Stones ☐ Hysterectomy
☐ Sexual Problems ☐ Hot Flashes
☐ Vaginal Discharge
☐ Last Pap _____
☐ Last Menstrual Period _____
☐ Last Mammogram _____

8. Musculoskeletal
☐ Muscle Aches ☐ Arthritis/Joint Pains
☐ Weakness ☐ Paralysis

9. Skin
☐ Rashes ☐ Hives
☐ Ulcers ☐ Sores
☐ Pigmented Moles ☐ Skin Cancer

10. Neurological
☐ Seizures ☐ Fainting
☐ Headaches ☐ Stroke
☐ T/A ☐ Speech Problems
☐ Balance Problems ☐ Paralysis
☐ Weakness

11. Psychiatric
☐ Depression ☐ Anxiety
☐ Sleep Problems ☐ Others

12. Endocrine
☐ Intolerance to Heat/Cold
☐ Thyroid Disease ☐ Diabetes
☐ Other

13. Heme/Lymphatic
☐ Enlarged Lymph Nodes
☐ Anemia ☐ Leukemia
☐ Platelet Problems ☐ Lymphoma
☐ Red Cell Problems
☐ Blood Clots - When/Where _____
☐ Anticoagulants - Dose _____

14. ☐ Other _____

I have fully reviewed the questionnaire and answered all questions truthfully and to the best of my knowledge. I understand that my answers could affect my health care.

"I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, Medicare, HMO Plans and Commercial Insurance Plans to Dr. Aye Moe Thu Ma and Dr. Alyssa Gillego. I hereby authorize said assignee to release any information necessary to secure payment on my behalf. I understand that I am financially responsible for all charges whether or not covered by insurance."

Patient Signature: _____ Date: _____

Insurance Information: _____ ID#: _____

Please fax any available radiology and pathology reports to our office at (212) 523-4799.

Mammogram: Left ☐ Right ☐

Ultrasounds: Left ☐ Right ☐

MRI: Breast ☐ Others ☐

CT Scans: Chest ☐ Abdomen ☐ Pelvis ☐

PET Scan: ☐

Bone Scan: ☐

Others: _____

Pathology reports: ☐

Left ☐ Right ☐

Type: ☐ Size: ☐ Grade: ☐

ER: ☐ PR: ☐ Her2: ☐

Please bring any available radiology films and reports and pathology reports to our office. Our office numbers are:

Dr. Ma: 212-523-4799, atma@chpnet.org
Dr. Gillego: 212-636-1857
Fax: 212-523-1761

Physician Signature: _____ Date: _____