The Hewitt Center *for* Breast Wellness
at Griffin Hospital

PATIENT DEMOGRAPHICS:			
Last Name:	First:		MI:
Address:			
City:	State:	Zip:	
Please check off the phone numbers you would like us to call regarding appointment conformations. **May we leave a message?** YES NO	☐ Home: ☐ Cell: ☐ Work:		
DOB:	Sex M___ F___	SSN:	
Email Address:			
Race:	Marital Status:	M___ S___ D___ W___	
Occupation:	Employer's Name:		
Emergency Contact:	Relationship:		
Home Phone	Cell Phone: Work:		
Primary Insurance:			
Name of Insured:	Relationship:	DOB	
Employer of Insured:			
Secondary Insurance:			
Name of Insured:	Relationship:	DOB	
Pharmacy Name:	Pharmacy Phone:		
Pharmacy Address:			

How did you hear about our practice?		**PLEASE LIST ALL THOSE INVOLVED IN YOUR HEALTH CARE**
Friend/Family:		Primary Care Doctor:
Advertisement: Where?		OBGYN:
Insurance Company:		Cardiologist:
Employer:		Please list any other doctors:
Walk/Drive-by:		
Other:		

In order to submit a claim for payment for the services covered under your policy, we must have your authorization to release medical information to your insurance company.

I authorize any holder of medical information to release it to my insurance carrier or its intermediaries for any claim purposes. I request that payment be made on my behalf. I understand that I am responsible for any balance not covered by this authorization or any balance unpaid by my insurance company.

Signature: _____ Date: _____

What brings you here today?

SURGICAL HISTORY	
Procedure	Surgery Date

MEDICATION HISTORY	
Medication/Drug Name	Dose and frequency

ALLERGIES/ADVERSE REACTION	
Medication/Drug	Type of Reaction
Any allergies to shellfish/Eggs YES / NO	

BREAST CANCER FAMILY HISTORY	
Do you have a Family History of Breast Cancer?	YES NO
Relationship:	
Age at Diagnosis:	
Relationship:	
Age at Diagnosis:	
Do you have a family history of Ovarian Cancer?	YES NO
Relationship:	
Age at Diagnosis:	
5 Year Gail Risk:	Lifetime Gail Risk

SOCIAL HISTORY

	YES	NO		YES	NO
Alcohol consumption			Tobacco Use		
How Much Per Day?			How Much?		
Sexually Active			Drugs?		
Exercise			Caffeine (Coffee/tea soda)		
Pets in Home			How Much Per Day:		
Ever had a blood transfusion?					

GYN HISTORY

Did you start your menstrual period before age 12?	Did you breastfeed:
Date of LMP:	If Post-menopausal, age at menopause:
Number of Pregnancies:	Bra Size:
Number of live births:	Date of Last Breast Imaging:
Age at First Child:	Have you ever had a breast biopsy: YES or NO
Are you nulliparous (never given birth) YES or NO	Results:
	Have you ever taken estrogen for hormone YES or NO Replacement therapy (HRT) If yes, how many years? _____
Have you ever been told YES or NO you have dense breasts	Have you been tested for BRCA1/BRCA2 YES or NO Results

FAMILY HEALTH HISTORY

Do you have any of your 1st degree relatives that are of Ashkenazi descent? YES NO

	AGE	ALIVE	DECEASED	UNKNOWN	HISTORY OF CANCER?	NOTES:
MOTHER						
FATHER						
SIBLING						
SIBLING						
SIBLING						
GRANDMOTHER						
GRANDMOTHER						
GRANDFATHER						
GRANDFATHER						
AUNT						
OTHER						

PAST MEDICAL HISTORY							
	YES	NO	NOTES		YES	NO	NOTES
Acid Reflux				Fibromyalgia			
Alcoholism/Substance Abuse				Glaucoma			
Anemia				Heart Attack			
Anxiety Disorder				Heart Disease			
Any blood relative who had anesthesia complications				High Blood Pressure			
Complications related to anesthesia				High Cholesterol			
Arrhythmia				Intestinal Problems-Ulcer, Hiatal Hernia			
Arthritis				Jaundice or Liver Disease			
Asbestos Exposure				Kidney Disease or Problems			
Asthma or Allergies				Lung Disease (Pneumonia, TB, Emphysema)			
Auto Immune Disease				Migraine Headaches			
Bladder Disease				Palpitation			
Bleeding Tendencies				Obesity			
Blood Clotting in lungs or legs				Osteopenia or Osteoporosis			
Breast Disease				Rheumatic Fever			
Cancer				Seizures, Convulsions, Epilepsy			
Cataracts				Sickle Cell Disease			
Angina Pectoris				Sleep Apnea			
Congestive Heart Failure				Stroke			
COPD				Thyroid Problems			
Depression, Mental illness				Venereal Disease			
Diabetes				Vitamin Deficiency			
Eczema				Genetic Mutation			
Fainting Spells							

REVIEW OF SYSTEMS

Please **Circle** Each Item As They Relate To Your Health

Constitutional:

Fatigue
Fever
Exercise intolerance
Night sweats
Significant weight gain
Weight gain (_____lbs)
Significant weight loss
Weight Loss (_____lbs)

Skin:

Abnormal Moles
Jaundice
Hives
Eczema
Rashes
Mole(s) changes

Eyes:

Dry Eyes
Irritation
Vision Change
Discharge

Ears Nose Mouth Teeth:

Hearing loss
Ear Pain
Sneezing Frequent
Nosebleeds
Bleeding gums
Snoring
Dry Mouth
Mouth Ulcers
Teeth Problems
Headaches
Oral Abnormalities
Nose/Sinus problems
Sore Throat
Frequent Nosebleeds
Teeth Abnormalities
Frequent or Severe headaches

Neck Symptoms:

Swollen Glands
Neck Stiffness

Pulmonary Symptoms:

Cough
Wheezing
Shortness of Breath
Coughing up Blood

Cardiovascular Symptoms:

Chest Pain
Shortness of Breath when Walking
Shortness of Breath when Laying Down
Leg Swelling
Palpitations
Arm Pain on Exertion

Gastrointestinal Symptoms:

Abdominal Pain
Vomiting
Vomiting Blood
Normal Appetite
Diarrhea
Constipation
Rectal Bleeding
History of GERD
Change in Appetite
Black or Tarry Stools
Frequent Diarrhea
Feeling Full Before Finishing Meals (Early Satiety)

Genitourinary Symptoms:

Incontinence
Difficulty Urinating
Hematuria
Increase Frequency
Urinary Frequency
Incomplete Emptying
Urinary Loss of Control

Musculoskeletal Symptoms:

Muscle aches
Muscle Weakness
Arthralgias/Joint Pain
Back Pain

Neurological Symptoms:

Loss of Consciousness
Weakness
Numbness
Seizures
Dizziness
Loss of Balance

Psychological Symptoms:

Depression
Anxiety
Sleep Disturbances
Feeling Safe in Relationship
Homicidal Thoughts
Suicidal Thoughts
Alcohol Abuse

Gynecological Symptoms:

Hot Flashes
Menstrual Bleeding
Vaginal Pain
Vaginal Itching or Burning
Vaginal Discharge
Issues with Sexual Function or Body Image
Dissatisfied with Appearance of Breast
Vaginal Dryness
Breast are too Large
Breast are too Small

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth
Address:	
Telephone:	Social Security #:
( ) I herby authorize Griffin Faculty Physicians to **RELEASE** medical information TO: (Initial in box to give us permission to share your medical information with another provider, family member, insurance provider)	( ) I hereby authorize Griffin Faculty Physicians to **OBTAIN** medical information FROM: (Initial in box to give us permission to get your medical information from another provider, ie. A previous doctor)

SPECIFIC INFORMATION TO BE RELEASED

Discharge Summary:		Laboratory Reports:		ER Records:	
Operative Reports:		Radiology Reports:		PT Records:	
Consultation Reports:		Pathology Reports:		Other:	

PURPOSE OF DISCLOSURE/USE OF MEDICAL INFORMATION

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

I understand that if the person or entity I designate to receive information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. (If applicable) I understand that the person I am authorizing to use/disclose information may receive compensation for doing so. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any of any information in writing at any time except to the extent that action has been taken by Griffin Hospital in reliance on this authorization. Request Revocation date:_____ Intl:_____

If not previously revoked, this consent will terminate within 90 days from the date of signature.

Patient/ Authorized Person's Signature: Date:

If the patient has not signed the form, please specify the signer's relationship to the patient and explain why the patient did not sign

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AUTHORIZATION TO OBTAIN MEDICATION HISTORY INFORMATION

Patient Name	Date of Birth
Address:	
Telephone:	Social Security #:

Please Initial in ONE of the boxes to indicate you authorization:

( ) I hereby authorize Griffin Faculty Physicians to OBTAIN my medication history electronically from my pharmacies to better facilitate my care. I understand the initial medication history download includes data from the past two years and that medication information will update periodically in the future:

OR

( ) I HEREBY do not authorize Griffin Faculty Practice to OBTAIN my medication history electronically from my pharmacies.

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Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:	Date of Birth:

I, _____, hereby acknowledge that the Griffin Hospital Notice of Privacy Practices has been made available to me, I understand that if I have further questions or complaints I may contact:

Griffin Hospital Privacy Officer
130 Division Street
Derby, CT 06418

I also understand that I am entitled to receive updates upon request if the Griffin Faculty Practice Notice of Privacy Practices is amended or changed in a material way.

_____
Signature

_____
Relationship to patient

_____
Date

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLWDGEMENT FROM PATIENT.

On_____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

( ) Patient declined to sign this Written Acknowledgement
( ) Patient did not understand the request to sign the Written Acknowledgement
( ) Other (specify)_____

_____
Name and title of employee

_____
Date