Mid La Surgical Specialists

Patient Information Sheet

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION DATE: _____

First Name:_____ M.I. _____ Last:_____

Mailing Address: _____City/St/Zip:_____

Home Phone: (___)_____ Work #: (___)_____ Cell #: (___)_____

E-mail:_____ Best Contact: □Email □Work □Cell □Home

Date of Birth:_____ Social Security #:_____

Sex: □ Male □ Female Marital Status: _____ Drivers License #: _____

Preferred Pharmacy: _____ Location: _____

Employer: _____ Occupation: _____

Employer's Address: _____City/St/Zip:_____

If Patient is a child/minor please provide the following:

Mother's Name: _____ Mother's SS #:_____

Date of Birth: _____ Employer:_____ Work Tel: (____)_____

Father's Name: _____ Father's SS #:_____

Date of Birth: _____ Employer:_____ Work Tel: (____)_____

SPOUSE INFORMATION

First Name:_____ M.I. _____ Last:_____

Social Security #:_____ Date of Birth: _____

Employer: _____ Occupation: _____

Employer's Address: _____City/St/Zip:_____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Tel (H): (____)_____ Tel (W): (____)_____ Cell: (____)_____

Address: _____

(YOU MUST COMPLETE & SIGN THE BACK OF THIS FORM!)

MEDICATION HISTORY CONSENT

An accurate medication history is very important in helping our physicians provide you with quality health care and assists in avoiding potentially dangerous drug interactions.

I hereby give my consent to Mid Louisiana Surgical Specialists to electronically obtain my medication history.

_____

Patient Signature / Legal Guardian

*Electronic information from your pharmacy and/or health insurance provider might not be complete. It's very important that you inform your physician of all medications that you routinely take, including over-the-counter medicine, vitamin supplements and herbal remedies.

REQUIRED INFORMATION

Medicare, in their efforts to assure that all patients have equal access to quality patient care, requires that we obtain the following information on all of our patients. We appreciate your assistance!

Do you consider yourself Hispanic/Latino? Yes No

Which category best describes your race? American Indian Asian Black/African American White Other:_____

PHOTO CONSENT – PROTECTED HEALTH INFORMATION

I understand that, in an effort to prevent medical identity theft, MLSS policy requires that my photo be placed in my medical record. I hereby consent to a photograph being made of me or my child/dependant. I understand that it is solely for the purpose of protecting my identity and protected health information_____

SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the physicians and staff on this case to release medical information to the pertinent insurance company(s) or third party carriers and request that payment be made directly to the billing entity. I also request that payment of benefits from my secondary insurance carrier be paid directly to the billing entity until otherwise notified.

OFFICE POLICY

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at the time of my visit.
3. I understand that I am required to pay my portion of any surgery/procedure charges prior to the procedure date.
4. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
5. I understand that my insurance card must be shown at each visit.
6. I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be canceled.
7. I understand that, in the event my account is turned over for collection, I will be responsible for payment of reasonable legal fees to collect same.
8. A copy of Mid Louisiana Surgical Specialists' financial policy has been made available to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Responsible Party

Mid LA Surgical Specialists

A Professional Medical Corporation

Wayne L. Watkins, M.D., F.A.C.S.
Darryl J. Aguilar, M.D., F.A.C.S.
Philip A. Cole, II, M.D.
J. Michael Conerly, M.D., F.A.C.S.
James N. Parrish, M.D., F.A.C.S.
Robert S. York, M.D., F.A.C.S.

Authorization for Release of Protected Health Information

Patient Identification

Patient Name _____ Date of Birth _____/_____/_____

Patient Address _____
Street City State Zip

Patient Social Security No. _____ Home Phone _____

Recipient Authorization

*IMPORTANT!! List all persons (doctors, family, friends, etc.) that you authorize Mid La Surgical Specialists to release your medical information to. **Anyone not listed will be unable to receive any of your medical information, written or verbal, from this clinic.*

I hereby authorize Mid La Surgical Specialists to release the information identified in this authorization form from the medical records of Mid La Surgical Specialists and provide such information to:

Referring physician(s)/Medical Facilities
List Physicians/Medical Facilities _____
_____

Family/Relative/Friend
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____

Information to be Released. Check all that apply and specify dates of service.

( ) Entire Medical Record _____
( ) Visit Notes _____
( ) Pathology Reports _____
( ) Lab Reports _____
( ) X-Ray Reports _____
( ) Other (specify) _____

Purpose of Information Release

( ) Further medical care
( ) Payment of Insurance Claim
( ) Legal Investigation
( ) Applying for Insurance
( ) Disability Determination
( ) Vocational rehab, evaluation
( ) At the request of the individual
( ) Other (specify): _____

Inclusion of Privileged Information

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

Patient Rights and Privacy

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.

- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- I understand that Mid La Surgical Specialists will not deny treatment on whether I sign the authorization.

I hereby release and discharge Mid La Surgical Specialists of any liability, and the undersigned will hold Mid La Surgical Specialists harmless for complying with this Authorization.

Signature of Patient: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

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NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities
We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. You have certain rights and we have certain legal obligations regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations.

Uses and Disclosures: How we may use and disclose Health Information about you.

The following categories describe examples of the way we may use and disclose your health information:

For Treatment: We may use health information about you to provide you medical treatment or services. We may disclose health information about you to doctors, nurses, and technicians, medical students, or other Practice personnel who are involved in taking care of you. For example, your health information may be provided to a physician or other health care provider to which you have been referred.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery or other health care services so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Our Physicians may use information in your health record to assess the care and outcomes in your case. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professional;

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing companies, transcription companies, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your Medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible).

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives our Practice participates in.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

When We Must Obtain Your Authorization: We must obtain your authorization before using or disclosing health information for the following purposes:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health/Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies

- Funeral Directors and Coroners
- National Security and Intelligence Agencies/Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based cities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Rights Regarding Your Protected Health Information: You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request an Amendment:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Practice Privacy Official.

  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **Right to Restrict Uses or Disclosures:** You have a right to ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

  If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

  We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree,

we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The Practice will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the Practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the Practice and include the effective date. In addition, each time you come to the Practice for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

PRACTICE PRIVACY OFFICIAL

Penny Rai, 3311 Prescott Rd, Ste 201, Alexandria, LA 71301. Phone: (318) 442-6767.

Patient's Name (please print)_____ Date:_____

Signature of Patient or Legal Guardian: _____

History and Physical

Patient Name: _____ DOB: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Reason for visit: _____

PAST MEDICAL HISTORY - Check all that apply to YOU!

- □ None
- □ Number of Pregnancies _____
- □ Number of Births _____
- □ Asthma
- □ Atrial Fibrillation
- □ Anxiety
- □ Autoimmune Disorder
- □ CVA / Stroke
- □ COPD-Emphysema
- □ Coronary Heart Disease
- □ Crohn's Disease
- □ CRF-Renal Failure
- □ Colon Cancer
- □ Cataract Extraction
- □ Anesthesia Complications
- □ Blood Transfusion
- □ Depression
- □ Diabetes – Type 1
- □ Diabetes – Type 2
- □ GI Bleed
- □ G E R D - reflux
- □ Heart Disease
- □ Hyperlipidemia
- □ Hypertension
- □ Hypothyroidism-Underactive
- □ Hyperthyroidism-Overactive
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Infertility
- □ Cirrhosis
- □ DVT-blood clots
- □ Kidney Disease
- □ Kidney Stone
- □ Liver Disease
- □ M I-Heart Attack
- □ Neurologic Disorder
- □ Osteoathritis
- □ Osteoporosis
- □ PVD-arterial disease
- □ PUD – Gastric ulcers
- □ Rheumatoid Arthritis
- □ Skin Cancer
- □ Seizure Disorder
- □ Thyroid Disorder
- □ Tuberculosis
- □ Valvular Heart Disease
- □ U T I – bladder infections
- □ Brain Tumor
- □ Varicose Veins/Phlebitis
- □ Breast Disease
- □ Cervical Cancer
- □ Colon Polyps
- □ Fibromyalgia
- □ Breast Cancer
- □ Prostate Cancer
- □ Other _____

PAST SURGICAL HISTORY - Check all that apply to YOU!

- □ None
- □ Abdominal-exploratory
- □ Amputation
- □ Dialysis Access
- □ C-Section
- □ Aortic Valve Replacement
- □ Appendectomy
- □ Aortic Surgery
- □ Back Surgery
- □ Breast Biopsy
- □ CABG-Heart Bypass
- □ Carotid Endarterectomy
- □ Carpel Tunnel
- □ Cataract Surgery
- □ Gallbladder
- □ Colon Resection
- □ Brain Surgery
- □ Weight loss surgery
- □ Hemorrhoidectomy
- □ Hernia Repair
- □ Hiatal Hernia Repair
- □ Hip Replacement
- □ Interventional Pain Procedure
- □ Knee Scope
- □ Knee Replacement
- □ Mitral Valve Replace
- □ Kidney Surgery
- □ Pacemaker
- □ Parathyroidectomy
- □ Lung Surgery
- □ Port Placement
- □ Port Removal
- □ Prostate Surgery
- □ Heart stent
- □ Rotator Cuff Repair
- □ Splenectomy
- □ Tubal Ligation
- □ Hysterectomy w/o ovaries
- □ Hysterectomy w/ovaries
- □ Thyroidectomy
- □ Tonsillectomy
- □ Bladder Sling
- □ Mastectomy/Lumpectomy
- □ Anesthesia Problems
- □ Surgical Complications
- □ Other _____

PAST FAMILY HISTORY - Check all that apply to IMMEDIATE FAMILY MEMBERS ONLY! List family member if applicable.

- □ FH Anemia _____
- □ FH Anesthetic Complication _____
- □ FH Blood Clots _____
- □ FH Breast Cancer _____
- □ FH Colon Cancer _____
- □ FH Ovarian Cancer _____
- □ FH Diabetes _____
- □ FH Heart Disease _____
- □ FH Hypertension _____
- □ FH Psychiatric Care _____
- □ FH Stroke _____
- □ FH Thyroid Disease _____
- □ FH Bowel Disease _____
- □ FH Kidney Disease _____
- □ FH Respiratory Disease _____
- □ FH Liver Disease _____
- □ FH Melanoma _____
- □ FH Weight Disorder _____

SOCIAL HISTORY – Circle/Complete all that apply to YOU!

MARITAL STATUS: Single Married Divorced Widow **LIVING ARRANGEMENTS:** Private Residence Nursing Home

ANY RELIGIOUS BELIEFS THAT WOULD AFFECT YOUR CARE? _____

TYPE OF WORK: _____ **LEVEL OF EDUCATION:** _____

TOBACCO USE: _____Never smoked _____ Current every day smoker _____ Current heavy tobacco smoker
_____Current light tobacco smoker _____ Current some day smoker How long? _____ yrs # packs per day _____
_____Former Smoker How long since you quit? _____ months/years Are you exposed to second-hand smoke? Yes No
_____Cigarettes _____ Cigars _____ Smokeless/Chewing

DRUG USE: Yes No **HIV RISK:** Yes No

ALCOHOL USE: Yes No Average drinks per day _____ per month _____

REGULAR EXERCISE: Yes No If yes, # of times per week: _____

Date of last Colonoscopy: _____ **Date of Last Mammogram:** _____

Review of Systems

Check all that apply to YOU!

GENERAL
- □ Fever
- □ Anorexia
- □ Weight loss

EYES
- □ Double vision
- □ Recent change in vision
- □ Eye pain
- □ Do you wear contacts/glasses? Yes No

GASTROINTESTINAL
- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Change in bowel habits
- □ Melena
- □ Blood in stool
- □ Jaundice
- □ Gas/bloating
- □ Indigestion/heart burn
- □ Dysphagia-difficulty swallowing

BREAST
- □ Left breast lump
- □ Right breast lump
- □ Nipple discharge
- □ Bloody nipple discharge
- □ Breast pain
- □ Abnormal mammogram
- □ Breast Enlargement
- □ Nipple/breast rash

CARDIOVASCULAR
- □ Chest Pain
- □ Palpitations-skipped beats
- □ Syncope-dizziness/fainting
- □ Peripheral edema-ankle swelling
- □ Shortness of breath

RESPIRATORY
- □ Cough
- □ Shortness of breath
- □ Coughing up blood
- □ Wheezing
- □ Pleuritic chest pain

VASCULAR
- □ Varicose veins
- □ Leg swelling
- □ Leg redness
- □ Leg coolness
- □ Pain in legs when walking
- □ Resting leg pain
- □ Pain in legs at night
- □ Blue toe(s)

GENITOURINARY (Female)
- □ Vaginal discharge
- □ Incontinence-urine leakage
- □ Dysuria-painful urination
- □ Blood in urine
- □ Frequent urination
- □ Abnormal Vaginal bleeding
- □ Pelvic Pain
- □ Is there a chance you are pregnant? Yes No

GENITOURINARY (Male)
- □ Painful urination
- □ Blood in urine
- □ Discharge
- □ Frequent urination
- □ Frequent night urination
- □ Difficulty urinating
- □ Incontinence-urine leakage
- □ Erectile dysfunction

WOUND
- □ Wound redness
- □ Wound drainage
- □ Wound pain
- □ Opening of wound
- □ Bleeding from wound
- □ Non-healing wound

DERMATOLOGY
- □ Suspicious lesions
- □ New skin lesions
- □ Changing mole(s)
- □ Rash
- □ Itching
- □ History of skin cancer
- □ SQ nodules (lumps)

NEUROLOGICAL
- □ Paralysis
- □ Numbness of an extremity
- □ Seizures
- □ Frequent headaches

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Memory loss
- □ Suicidal thoughts
- □ Hallucinations
- □ Paranoia
- □ Phobia
- □ Confusion

ENDOCRINE
- □ Cold intolerance
- □ Heat intolerance
- □ Excessive thirst
- □ Excessive eating
- □ Unusual weight change

HEME
- □ Abnormal bruising
- □ Bleeding
- □ Enlarged lymph nodes
- □ Sickle cell anemia
- □ Recent fever infections

MUSCULOSKELETAL
- □ Back pain
- □ Sciatica-nerve issues
- □ Arthritis
- □ Bone/joint pain

OTHER
- □ Stoma redness
- □ Pain around stoma
- □ Discharge from stoma
- □ Pain from venous catheter
- □ Redness at vascular access site
- □ Purulent drainage from vascular access site.

MID LOUISIANA SURGICAL SPECIALISTS

Dr. Wayne L. Watkins   Dr. J. Michael Conerly
Dr. Darryl J. Aguilar   Dr. James N. Parrish
Dr. Philip A. Cole, II   Dr. Robert S. York

MEDICATION FLOW SHEET

Name: ______________________________   Weight: ____________________

Allergies: ____

____

Date	Medication	Unit Dose	How often do you take it?	MD/Nurse

13. Have you ever taken hormones? No_____ Yes_____ When? _____

Type:_____ How long:_____

Are you currently taking hormones? No_____ Yes_____

14. Have you noticed any lump(s) in your breast? No_____ Yes_____

If yes, which breast? Right_____ Left_____ When?_____

Did you or your doctor first notice the lump(s)? Me_____ Doctor_____

Has it enlarged? No_____ Yes_____ If yes, Slowly_____ Rapidly_____ Overnight_____

15. Do you have or have you ever had breast soreness around the time of your menstrual period?

No_____ Yes_____ If yes, Mild_____ Severe_____

16. Have you ever had a breast operation? No_____ Yes_____ If yes, answer the following:

Which Breast? Right_____ Left_____ Date: _____

Diagnosis: _____

Any subsequent chemotherapy? No_____ Yes_____ If yes:

Name of doctor:_____

Address (if known):_____

17. Have you noticed any nipple discharge? No_____ Yes_____

If yes, was there any blood? No _____ Yes _____

If yes, which breast? Right_____ Left_____

Please describe:_____

_____

18. Have you noticed any scaling of the nipples? No_____ Yes_____

If yes, which breast? Right_____ Left_____

Patient Name: _____ Date: _____

19. Have you noticed any dimpling of the skin? No_____ Yes_____

If yes, which breast? Right_____ Left_____

20. Have you lost any weight? No_____ Yes_____ About_____ pounds

21. Do you have any new and persistent bone pain? No_____ Yes_____

If yes, location:_____

22. Have you ever had a mammogram? No_____ Yes_____

If yes, date(s): _____

Facility:_____

Doctor who ordered mammogram:_____

Patient Name: _____ Date: _____

Mid LA Surgical Specialists

BREAST QUESTIONNAIRE

☐ Wayne L. Watkins, MD ☐ J. Michael Conerly, MD

☐ Darryl J. Aguilar, MD ☐ James N. Parrish, MD

Today's Date: _____

Patient Name:_____ Referring Doctor:_____

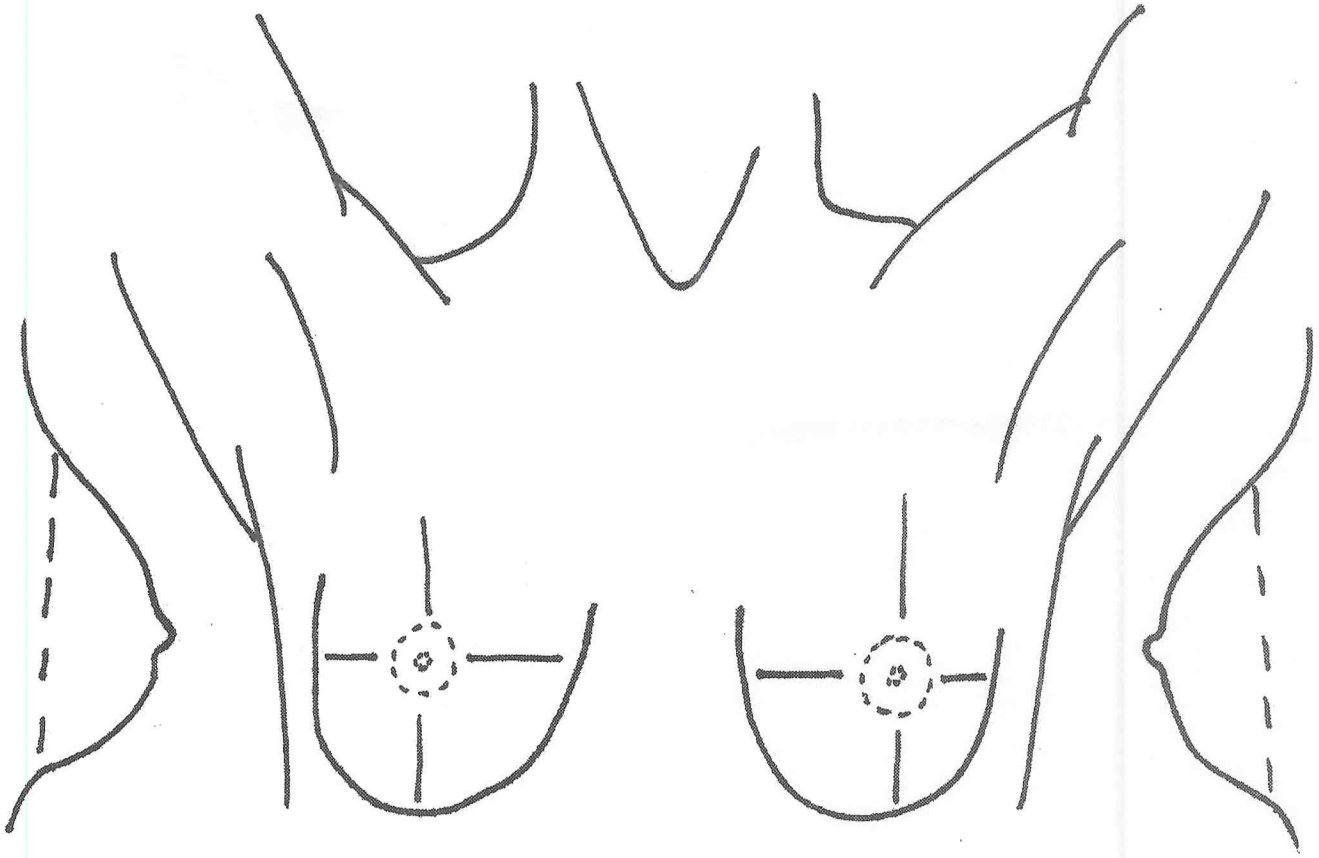
1. Age:_____ years. Age when started having menstrual cycles:_____
2. Date last menstrual period began, if still menstruating:_____
3. Age of onset of menopause (if applicable):_____ years.
4. Number of pregnancies:_____
5. Number of children born alive:_____
6. Did you nurse any children? No_____ Yes_____ How many?_____
7. Age at first full-term birth:_____
8. Have you had a hysterectomy? No_____ Yes_____

   If yes, when? _____ By whom?_____
9. Have you had removal of your ovaries? No_____ Yes_____

   If yes, when? _____ By whom?_____
10. Has anyone in your family had breast cancer? No_____ Yes_____

    If yes, who? _____
11. Has anyone in your family ever had any other type of cancer? No_____ Yes_____

    If yes, who & type? _____
12. Do you:
    - Drink coffee? No_____ Yes_____ About _____ cups per day.
    - Drink cokes? No _____ Yes_____ About _____ per day.
    - Drink tea? No _____ Yes_____ About _____ cups per day.
    - Eat chocolate No _____ Yes_____



FOR PHYSICIAN'S USE

Physician Signature:_____ Date:_____

Reviewed by: _____ Date_____

Reviewed by: _____ Date_____

Reviewed by: _____ Date_____

Patient Name: _____ Date: _____