Miami Breast Center
Breast Surgery & Reconstruction

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PATIENT INTAKE FORM

Welcome to the Miami Breast Center. Please take your time and carefully fill out this form. The information you provide will assist us in offering you personalized first class service. We are committed to ensuring that you are as comfortable as possible and have a positive and healing experience with us. Please fill out your name at the bottom of each page and sign on page 5.

PATIENT INFO

NAME _____ DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ SSN _____

E-MAIL _____ CELL PHONE _____

GENDER AT BIRTH ☐ MALE ☐ FEMALE CURRENT GENDER ☐ MALE ☐ FEMALE

ARE YOU A COSMETIC PATIENT? ☐ YES ☐ NO

ARE YOU A BREAST CANCER PATIENT AND HERE FOR RECONSTRUCTION? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT THE MIAMI BREAST CENTER? _____

EMERGENCY CONTACT

NAME _____ PHONE _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID # _____

INSURANCE PHONE # _____ GROUP # _____

INSURED NAME _____ SS# _____

SECONDARY INSURANCE _____ ID # _____

INSURANCE PHONE # _____ GROUP # _____

HEALTH CARE PROVIDER

PRIMARY CARE PHYSICIAN NAME _____ PHONE# _____

ADDRESS _____ CITY _____

_____ STATE _____

(Breast Cancer Patients Will Fill Additional Information At Bottom Of Form)

MEDICAL INFORMATION

WHEN WAS YOUR LAST PHYSICAL EXAM?

_____

DO YOU SMOKE? ☐ YES ☐ NO

IF SO HOW MUCH?

_____

TEST	WHEN	FOR WHAT REASON?	RESULTS
CT SCAN			
EKG			
MRI			
ULTRASOUND			
CHEST X-RAY			
MAMMOGRAM			

NAME _____

MEDICATIONS / SUPPLEMENTS

MEDICATION / SUPPLEMENT NAME	HOW MANY DO YOU TAKE DAILY?	REASON FOR TAKING MEDICATION / SUPPLEMENT

ALLERGIES:

☐ Aspirin ☐ Iodine ☐ Penicillin ☐ Versed ☐ None

☐ Codeine ☐ Morphine ☐ Sulfa ☐ Valium Other _____

PAST OR PRESENT MEDICAL PROBLEMS:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cataracts
☐ Chronic Anxiety
☐ Frequent Urinary Infections
☐ Gallstones
☐ Glaucoma
☐ Chronic Cough
☐ Chronic Lung Disease
☐ Chronic Sinusitis
☐ Cirrhosis of Liver
☐ Colon Cancer
☐ Colon Polyps
☐ Diabetes
☐ Depression
☐ Paralysis
☐ Parkinson's
☐ Phlebitis
☐ Pneumonia
☐ Seizures
☐ Sexually Transmitted Disease
☐ Skin Cancer
☐ Stomach / Duodenal Ulcer
☐ Stroke
☐ TB (Tuberculosis)
☐ High Blood Pressure
☐ High Cholesterol
☐ High Triglycerides
☐ Irregular Heartbeat
☐ Kidney Disease / Failure
☐ Kidney Infection
☐ Polio
☐ Psoriasis
☐ Reflux
☐ Rheumatic Fever
☐ Kidney Stones
☐ Lupus
☐ Migraines
☐ Milk Intolerance
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pancreatitis
☐ Ovarian Cyst
☐ Diverticulitis
☐ Ear Infections
☐ Emphysema
☐ Fatty Liver
☐ Gout
☐ Groin Hernia
☐ Heart Attack
☐ Heart Murmur
☐ Hepatitis
☐ Hiatal Hernia

Other _____

SOCIAL HISTORY / MARITAL STATUS:

☐ Divorced
☐ Married
☐ Separated
☐ Single
☐ Widowed

Do you have children?

☐ YES ☐ NO

If so how many _____

Have you ever breast fed?

☐ YES ☐ NO

If yes how long? _____

NAME _____

SOCIAL HISTORY RECREATIONAL DRUGS:

- ☐ I have never used recreational drugs
- ☐ I have used recreational drugs in the past
- ☐ I am currently using recreational drugs
- ☐ I have been treated for substance abuse

SOCIAL HISTORY TOBACCO:

- ☐ I use tobacco products
- ☐ I quit using tobacco products
- ☐ I have never used tobacco products

HEMATOLOGIC:

- ☐ Bleeding doesn't stop easily
- ☐ Frequent bruising
- ☐ Thrombosis / blood clots
- ☐ Transfusion
- ☐ Enlarged Glands

Other _____

SOCIAL HISTORY AICOHOL:

- ☐ Never
- ☐ Rarely
- ☐ Daily
- ☐ More than 2 days / week
- ☐ Less than 2 days / week
- ☐ I quit using alcohol

ARE YOU CURRENTLY UNDER THE CARE OF A SPECIALIST (OTHER THAN BREAST CANCER)?

NAME AND ADDRESS

_____

SPECIALTY? _____

PAST MEDICAL HISTORY:

Surgeries

PROCEDURES	YEAR PERFORMED

NAME _____

BREAST CANCER PATIENTS FILL SECTION BELOW:

ARE YOU CURRENTLY UNDER THE CARE OF AN ONCOLOGIST? ☐ YES ☐ NO

PHYSICIAN NAME _____ PHONE _____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

DATE OF YOUR LAST EXAM? _____ DIAGNOSIS _____

ARE YOU CURRENTLY IN CHEMOTHERAPY TREATMENT ☐ YES ☐ NO

IF YES: Please list chemo drugs:

_____ _____ STARTING CHEMO DATE _____

_____ _____ ENDING CHEMO DATE _____

Have you had radiation: ☐ YES ☐ NO

IF YES, DATES RADIATED:

STARTING _____ ENDING _____

Are you scheduled for radiation ☐ YES ☐ NO

START DATE _____ END DATE _____

RADIATION DOCTOR INFORMATION:

PHYSICIAN NAME _____

PHONE _____

ADDRESS _____

_____

HIPPA (PRIVACY PRACTICE FORM) WILL BE PROVIDED ON ARRIVAL TO THE OFFICE

ALL PATIENTS PLEASE SIGN:

SIGNATURE _____ DATE _____

NAME _____