South Florida Breast Specialists

Denise Sanderson, M.D.
931 SE Ocean Blvd., Suite B-2
Stuart, FL 34994
Phone (772) 872-6913 Fax (772) 872-6924

First Name:_____ Middle Initial:_____ Last: Name_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Date of Birth:_____

Social Security Number: _____ Sex: ( ) Male ( ) Female

Home Phone: _____ Work:_____ Cell:_____

Preferred Phone Number: ( ) Home ( ) Work ( ) Cell Preferred Language:_____

Race/Ethnicity/Ancestry: ( ) Black ( ) White ( ) Hispanic ( ) Pacific Islander ( ) Asian

( ) American Indian/Native Indian ( ) Ashkenazi Jewish Descent ( ) Other _____

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Work Status: ( ) Not Employed ( ) Full Time ( ) Part Time ( ) Disabled ( ) Retired

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

Referring Provider:_____ Primary Care Provider:_____

Pharmacy Name:_____ Address:_____

Phone Number:_____ Fax:_____

Advanced Directives? ( ) Living Will ( ) DNR Power of Attorney:_____

CONSENT FOR MEDICATION HISTORY

Do you consent for South Florida Breast Specialists to obtain your medication history from your pharmacy electronically if they are available? ( ) YES ( ) NO

INSURANCE INFORMATION

PRIMARY Insurance:_____ SECONDARY Insurance:_____

Policy Holder (If other than self):_____ SS#:_____

Relationship to patient:_____Date of Birth:_____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. DENISE SANDERSON. I REALIZE THAT I AM RESPONSIBLE TO PAY NON-COVERED SERVICES (INCLUDING COLLECTION COSTS IN THE EVENT OF DEFAULT). A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS ORIGINAL. I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO SECURE PAYMENT.

PATIENT SIGNATURE:_____ DATE:_____

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By signing this form, you are granting consent to Dr. Denise Sanderson, M.D. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to amend your protected health information for the purposes of treatment, payment or health care operations, in writing, explaining your reasoning for the amendment. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

I understand and authorize, that at times it will be necessary for Dr. Sanderson and/or Staff to call my home or place of business and leave messages on an answering machine, voice mail or e-mail.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request.

Signature:_____

Date:_____

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FAMILY AND FRIEND RELEASE OF INFORMATION

I give permission to allow into the exam room, discuss my care with, and release information to the following listed individuals:

NAME	RELATIONSHIP	PHONE NUMBER

Patients Printed Name

Patients Signature

Date

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REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment here today. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function.

CONSTITUTIONAL

- ☐ Chills
- ☐ Daytime drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight gain
- ☐ Weight loss

EYES

- ☐ Use of corrective lenses
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration

EAR/NOSE/THROAT

- ☐ Difficulty/loss of hearing
- ☐ Ringing in the ears
- ☐ Frequent ear aches
- ☐ Discharge from the ear
- ☐ Attacks of vertigo
- ☐ Sinus trouble
- ☐ Nasal blockage
- ☐ Frequent sneezing
- ☐ Frequent sore throat
- ☐ Snoring
- ☐ Recent change in voice quality
- ☐ Sleep apnea
- ☐ Difficulty in swallowing
- ☐ Nose bleeds

Respiratory

- ☐ Asthma
- ☐ Recent bronchitis or chest cold
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ COPD
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Chest discomfort
- ☐ Fluid on the lungs
- ☐ Stroke
- ☐ Blood clot in artery or vein
- ☐ "Black out spells"
- ☐ Aneurysm of any blood vessel
- ☐ Swelling of the legs
- ☐ Heart surgery

GASTROINTESTINAL

- ☐ Ulcer
- ☐ Frequent heartburn or indigestion
- ☐ Hiatal hernia
- ☐ Acid Reflux
- ☐ Poor appetite
- ☐ Gall bladder attacks
- ☐ Chronic constipation
- ☐ Bright blood bowels or rectum
- ☐ Abnormal stool
- ☐ Liver disease or jaundice

Kidneys/Urinary Tract

- ☐ Kidney disease or failure
- ☐ History of kidney dialysis
- ☐ Kidney stones or infection
- ☐ Pain/burning with urination
- ☐ Trouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Frequent night urination
- ☐ Bladder infections during the past year
- ☐ Blood in urine during past year

MUSCLES/BONES JOINTS

- ☐ Arthritis
- ☐ Chronic back trouble
- ☐ Bone or joint surgery in the past year

NERUOLOGICAL

- ☐ Migraines
- ☐ Epilepsy or seizures
- ☐ Date of last seizure

  _____

ENDOCRINE/METABOLISM

- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Unusual hair loss or growth
- ☐ Goiter
- ☐ Diabetes

BLOOD

- ☐ Bleeding or bruising tendency
- ☐ Previous blood transfusion
- ☐ History of hepatitis

PSYCHOLOGIC

- ☐ Anxiety
- ☐ Loss or change in appetite
- ☐ Behavioral change
- ☐ Bi-polar disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory loss
- ☐ Mood change

_____

INITIAL

_____

DATE

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Breast History:

Why are you here today:

( ) My doctor feels something in my breast

( ) I feel something in my breast

( ) Abnormal breast imaging (Mammogram, ultrasound, MRI)

( ) Breast Pain

( ) Other_____

( ) Skin Changes on the breast

Have you ever had a breast biopsy? ( ) YES ( ) NO Which Breast? ( ) LEFT ( ) RIGHT

If you marked yes, what were the results? ( ) Malignant (cancer) ( ) Benign (it was NOT cancer)

If Malignant, describe the treatment you had below: (Surgery, Chemotherapy, Radiation, Etc.)

_____

_____

_____

Have you ever had genetic testing? ( ) YES ( ) NO If yes, what were the results?_____

MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Please list all drug names/allergens

_____

_____

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PERSONAL HABITS

TOBACCO

- ☐ Yes- Packs per day: _____
- ☐ No
- ☐ Quit- Date:_____

ALCOHOL

- ☐ Yes- Drinks per day: _____
- ☐ No
- ☐ Quit- Date:_____

CAFFEINE

- ☐ Yes- How Much:_____
- ☐ No
- ☐ Quit

RECREATIONAL DRUGS

- ☐ Yes
- ☐ No
- ☐ Quit- Date:_____

MEDICATIONS

Please list all medications INCLUDING over the counter vitamins/supplements that you are currently taking

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please list any SIGNIFICANT family medical conditions. Examples: Cancers, Heart disease, diabetes

Mother:_____

Father:_____

Sisters:_____

Brothers:_____

Other:_____

GYNECOLOGICAL HISTORY

Age at first period:_____ Are you still having periods? ( ) YES ( ) NO Date of last period:_____

If yes, are they regular? ( ) YES ( ) NO If no, how old were you when they stopped?_____

Why did they stop? ( ) Menopause ( ) Hysterectomy ( ) Ablation # of Pregnancies:_____

# of Life births:_____ Did you breast feed? ( ) YES ( ) NO Age at first pregnancy:_____

Contraceptives (Yes/No, What type? How Long?)_____

Hormone Replacement Therapy (Yes/No, What type? How long?)_____