SENTARA
RMH Breast Care

Welcome to Sentara RMH Breast Care

Dear Patient:

The team at Sentara RMH Breast Care welcomes you to our practice. We will do our best to make your visit pleasant, efficient and informative. You should plan two hours for your appointment.

Please complete the enclosed packet and bring it with you to your scheduled appointment. The information must be completed before you see the provider. If you have difficulty completing the forms, please call our office at 540-689-4800 for assistance.

_____has been scheduled with Dr. Heidi Rafferty, Bryn Mullet Good, N.P. or Vicki Krauss, NP.

Appointment Date: _____**Time:**_____

Please arrive 30 minutes prior to your appointment to complete the initial registration process. If you are late for your appointment we will need to reschedule.

What to Bring

1. COMPLETED paperwork
2. Insurance Cards. In order to load your insurance information for billing, we must have the insurance policy holder's information: (Name, DOB, SSN)
3. All Medications (including over the counter) in their original bottles
4. Imaging films (Mammograms, Ultrasounds, etc—if done anywhere other than Sentara RMH.)

Copays

Insurance copays are REQUIRED at the time of registration. We accept cash, check and credit cards (Visa, MasterCard and Discover). If you do not bring your insurance card with you OR if you do not have insurance, you will be responsible for a payment of $50 at the time of service, unless other arrangements have been made prior to your visit. If you have payment concerns, we will be glad to discuss those with you prior to your visit. If you are unable to pay your copay we will gladly reschedule your appointment.

Cancellations

If you need to cancel your appointment, please call540-689-4800. Contact us at least 24 hours prior to appointment. If you fail to cancel your appointment in a timely fashion, it may be considered a missed appointment. Three missed appointments in a 12-month period may be cause for dismissal from the practice. We do take issues into consideration, so call our office and let us know why you missed your appointment.

Refills

Please allow up to 48 hours for refill requests to be fulfilled.

Thank you for choosing Sentara RMH Breast Care. We look forward to providing your care.

(rev 10/14)

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Patient Name: _____ **Date of Birth:** _____

Reason for your visit: _____

Past and Current Personal History (Medical Problems, Illnesses, Surgeries):

1. List ALL of your **medical** problems:

_____

_____

_____

2. List ALL of your major **surgeries**:

_____

_____

Have you ever had a breast biopsy? Y / N If yes, diagnosis:_____

3. How old were you when you started your period? _____ Are you pregnant now? Y / N

How many pregnancies? _____ Age at first live birth? _____

4. Have you had a Hysterectomy? _____

At what age did you have a hysterectomy: _____ Were one or both ovaries removed: _____

Have you used hormone replacement therapy? Y / N If so, how long? _____

5. Have you ever had a reaction to anesthesia: _____ Type: _____

Medications that you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

_____	_____
_____	_____
_____	_____

Family History: Do any of the following CANCERS run in your family:

Breast Cancer Y / N Who/what age: _____

_____

Ovarian Cancer Y / N Who/what age: _____

Other cancers? _____

Osteoporosis Y / N

Social History:

Occupation: _____

Do you use tobacco products? _____ If yes, type: _____

How many packs per day: _____ How many years: _____

Do you drink alcohol? Y / N Social / Heavy

Do you use street drugs? Y / N If yes, type: _____

Please indicate if you have any of the following symptoms by circling Y for Yes and N for No

Constitutional		
Fatigue	N	Y
Fever	N	Y
Weight gain	N	Y
Weight Loss	N	Y
Cardiovascular		
Chest pain	N	Y
Shortness of breath (dyspnea)	N	Y
Edema	N	Y
Palpitations	N	Y
Genitourinary		
Back pain	N	Y
Painful Urination (Dysuria)	N	Y
Frequent urination	N	Y
Blood in urine (Hematuria)	N	Y
Passage of Stones/Gravel	N	Y
Urinary Incontinence	N	Y
Neuro		
Loss of consciousness	N	Y
Hematological		
Thromboembolic event(blood clot)	N	Y
HEENT		
Headache	N	Y
Double vision (diplopia)	N	Y
Hearing loss	N	Y
Ringing in ears (Tinnitus)	N	Y
Vascular		
Varicose Veins		
Reproductive/Genitourinary (Female)		
Age at first menstrual period		
Last period date		
Age at menopause		
Hormone replacement	N	Y
Type of hormone replacement		
How long on hormones		
Breast discharge	N	Y
Breast lumps	N	Y
Breast pain	N	Y
Do you do self breast exams	N	Y
Last mammogram		
Hot flashes	N	Y
Vaginal dryness	N	Y

Reproductive (Male)		
Testicular Lumps (mass)	N	Y
Dermatologic		
Itchiness (pruritis)	N	Y
Rash	N	Y
Respiratory		
Cough	N	Y
Snoring	N	Y
Sleep Apnea	N	Y
Do you use Sleep Machine/CPAP	N	Y
Endocrine		
Goiter	N	Y
Male: Enlarged breast (Gynecomastia)	N	Y
Gastrointestinal		
Abdominal pain	N	Y
Blood in stool	N	Y
Heartburn	N	Y
Nausea	N	Y
Vomiting	N	Y
Hematological		
Easy bruising	N	Y
Easy bleeding	N	Y
Musculoskeletal		
Bone or joint symptoms	N	Y

Hereditary Cancer Risk Assessment

Heidi Rafferty, MD
Sentara RMH Breast Care Clinic

Patient Name: _____ Date of Birth: _____

Most of the time cancer happens by chance. However, in some families cancer may be caused by changes in certain genes that can be passed from generation to generation. These genetic changes significantly increase a person's risk for certain cancers, including a second cancer in those who already been diagnosed. Family members will benefit from this information, as will you, since heredity cancer risk can be significantly reduced with the right medical interventions. A careful review of your family history is an essential first step. so please check all the boxes that apply to you **and/or** your family (on both your mother's or father's side including parents, siblings, grandparents, aunts, uncles, or cousins.

Have you been diagnoses with>>>	Yes	No	Uncertain
Breast cancer before the age of 50?	☐	☐	☐
Ovarian Cancer at any age?	☐	☐	☐
Two breast cancers, or breast and ovarian cancer?	☐	☐	☐
Male breast cancer at any age?	☐	☐	☐
Melanoma?	☐	☐	☐
Prostate Cancer?	☐	☐	☐
Colon or Uterine Cancer before age 50?	☐	☐	☐
Colon or Uterine Cancer at any age with family history of either?	☐	☐	☐
Two colon cancers, or colon and uterine cancer?	☐	☐	☐
Gastric, Ovarian, ureter/renal pelvis, biliary, tract cancer?	☐	☐	☐
Small bowel, pancreas, brain, or sabaceous adenoma cancer?	☐	☐	☐
15 or more colon polyps (can be cumulative)?	☐	☐	☐
Two or more melanomas?	☐	☐	☐
Melanoma and pancreatic cancer?	☐	☐	☐
Are you of Ashkenazi Jewish ancestry?	☐	☐	☐

Have ANY of your FAMILY members been diagnosed with…	Yes	No	Uncertain
(*Please indicate **maternal** or **paternal** as they are both important)*			
Breast cancer before the age of 50?	☐	☐	☐
Ovarian Cancer at any age?	☐	☐	☐
Two breast cancers, or breast and ovarian cancer?	☐	☐	☐
Male breast cancer at any age?	☐	☐	☐
Melanoma?	☐	☐	☐
Prostate Cancer?	☐	☐	☐
Colon or Uterine Cancer before age 50?	☐	☐	☐
Colon or Uterine Cancer at any age with family history of either?	☐	☐	☐
Two colon cancers, or colon and uterine cancer?	☐	☐	☐
Gastric, Ovarian, ureter/renal pelvis, biliary, tract cancer?	☐	☐	☐
Small bowel, pancreas, brain, or sabaceous adenoma cancer?	☐	☐	☐
15 or more colon polyps (can be cumulative)?	☐	☐	☐
Two or more melanomas?*	☐	☐	☐
Melanoma and pancreatic cancer?*	☐	☐	☐
(Can be two cancers in one person, or two or more people in your family with these cancers)*			

If any of the boxes are checked, you have a person or family history suggestive of one of the more common heredity cancer syndromes and are a candidate for further risk assessment and, if appropriate, genetic testing to determine if a gene change exists. We will discuss this with you and provide additional information that will help you understand your individual risk and how to best address this risk.

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Tyrer-Cuzick Risk Model Questionnaire

1. Woman's Age: _____ 2. Date of first menses (menstrual period): _____ 3. Age at birth of first child: _____

4. Are you of Ashkenazi heritage? ❒ Yes ❒ No

5. Have you had any biopsies done? ❒ Yes ❒ No

6. Were the biopsy results . . .
   ❒ Hyperplasia without Atypia ❒ Fibrocystic changes ❒ Radial scar
   ❒ Atypical Hyperplasia ❒ LCIS ❒ Ovarian Cancer

7. Height: _____ Weight: _____

8. Are you: ❒ Premenopausal ❒ Perimenopausal ❒Post-menopausal _____ Age at menopause (if applies)

9. Have you used Hormone Replacement Therapy? ❒ YES (estrogen only or combined) ❒ NO
   If yes, for how may years did you use this therapy? _____
   How long ago did you use this therapy? ❒ More than 5 years ago ❒ Less than 5 years ago ❒ Current User

10. Do you have any family members diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, who? _____

11. Has your mother ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age was she diagnosed? _____

12. Has your maternal grandmother ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age was she diagnosed? _____

13. Has your paternal grandmother ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age was she diagnosed? _____

14. How many sisters do you have? _____

15. Have any of your sisters ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age were they diagnosed? _____

16. Do you have any half sisters? ❒ Yes ❒ No _____ Number of half sisters
    Have any of your half sisters ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No

17. How many paternal aunts do you have? _____
    Have any of your paternal aunts ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age were they diagnosed? _____

18. How many maternal aunts do you have? _____
    Have any of your maternal aunts ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, what ages were they diagnosed? _____

19. How many cousins do you have? _____ Have any been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age were they diagnosed? _____
    Is the cousin from a paternal or maternal aunt or uncle? _____

20. Do you have any daughters? ❒ Yes ❒ No _____ Number of daughters
    Have any of your daughters ever been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age were they diagnosed? _____

21. How many nieces do you have? _____ Have any been diagnosed with breast or ovarian cancer? ❒ Yes ❒ No
    If so, at what age were they diagnosed? _____

22. Has anyone in your family ever had genetic testing for breast and ovarian cancer? ❒ Yes ❒ No
    If so, who and what were the results? _____