BREAST & SURGICAL
ONCOLOGY
at The Poche Centre

40 Rocklands Road
North Sydney NSW 2060
Tel: 02 9911 7250
Fax: 02 9954 9938

Patient Information Sheet

Mr/Mrs/Ms/Miss/Dr _____

Title (Circle one) **First Name** **Middle Name** **Surname**

Preferred Name _____ **Date of birth** _____

Address: _____

Home Phone _____ **Mobile** _____ **Work** _____

Occupation: _____ **Email:** _____

Medicare No _____ **Patient Ref No.** _____ **Expiry** _____

Private Health Fund _____ **Membership No.** _____ **Ref** _____

Pension/DVA Card No _____ **Expiry** _____ **Type (circle) Aged/Health Care/Disability/Other**

Name of next of kin _____ **Relationship** _____ **Tel No** _____

GP Practice Name and Address _____

_____ **GP Tel No.** _____

Please add other doctors (apart from your GP) requiring copy of correspondence

_____

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.
4. De-identified information for quality assurance and research activities of the unit.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signed _____ **Date:** _____

Patient Name (Please print) _____

INITIAL CONSULTATION INFORMATION
(to be completed by all female breast patients)

NAME: _____

PART A: Breast risk assessment

Do you have a history of breast disease or breast operations? Yes ☐ No ☐
If yes, please list type and year.

_____

_____

Do you have a family history of breast cancer? Yes ☐ No ☐
If yes, please provide details (relative, mother's or father's side, age at diagnosis).

_____

_____

Do you have a family history of other cancers? Yes ☐ No ☐
If yes, please provide details (relative, mother's or father's side, age at diagnosis).

_____

_____

Number of previous pregnancies (including miscarriages and/or terminations) _____

Number of full-term pregnancies _____

Age at first pregnancy (if applicable) _____

Number of children breastfed and for how long _____

Have you had infertility treatment in the past? (eg IVF or Clomid) Yes ☐ No ☐

Age first period commenced _____

Have you been through menopause? Yes ☐ No ☐ Not sure ☐

Age menopause commenced (if relevant) _____

Have you had a hysterectomy? Yes ☐ No ☐

If yes, were the ovaries removed at the same time? Yes ☐ No ☐

Are you currently taking the oral contraceptive pill? Yes ☐ No ☐

If no, have you taken the oral contraceptive pill in the past? Yes ☐ No ☐

If yes, for how long and when did you stop? _____

Are you currently taking hormone replacement therapy (including 'natural' or 'bio-identical' products)? Yes ☐ No ☐

If no, have you taken hormone replacement therapy in the past? Yes ☐ No ☐

If yes, for how long and when did you stop? _____

Have you had previous radiotherapy? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

If yes, how many cigarettes per day? _____

Do you drink alcohol? Yes ☐ No ☐

If yes, how many standard drinks per day? _____

Please see over

PART B: General information

Occupation _____

Relationship status (single, married, de facto, divorced) _____

Who lives with you at home? (include partner's name if applicable)_____

_____

What is your ethnic background? _____

Do you have any Ashkenazi Jewish ancestry? Yes ☐ No ☐

Do you have any allergies? Yes ☐ No ☐

If yes, please list them _____

_____

Do you have diabetes? Yes ☐ No ☐

Are you asthmatic? Yes ☐ No ☐

Are you on Aspirin/Warfarin/blood thinners? Yes ☐ No ☐

What other health issues do you have? _____

_____

_____

What medications are you currently taking? _____

_____

_____

Are you taking any complementary or alternative medicines? Yes ☐ No ☐
(such as herbal remedies or high doses of vitamins)

If yes, which ones? _____

_____

Height _____

Weight_____