BREAST & SURGICAL
ONCOLOGY
at The Poche Centre

40 Rocklands Road
North Sydney NSW 2060
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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

NAME:______________________

____

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 ______________