



# Breast Patient Information Form

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_ Married/Single/Divorced/Widowed

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone numbers:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer: \_\_\_\_\_ (If the patient is a minor, list the guardian's employer)

Employer's address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

We are sensitive to your privacy wishes. In the following sections, please help us understand how we may best communicate with you, and how we may communicate about you to other health care providers.

Communication by texting and email is convenient, efficient, and a part of daily life for many people. It is important that you understand that email and text communications between you and us are not encrypted and therefore not secure. If you communicate with us from your workplace computer, your employer and its agents may have access to these communications. Any email communication between you and us may become part of your medical record and be accessible to the office staff as needed.

- Yes, I consent to texting communication with Dr. Kunkel and the office staff
- I understand that I am responsible for providing Dr. Kunkel's office staff of any updates to my email address
- I understand that I may revise or withdraw my consent at any time by notifying the office of this desired change
- No, I prefer not to have email communication
- No, I prefer not to have text communication
- Please list your email address only if you authorize Dr. Kunkel and the office staff to communicate with you by email:

\_\_\_\_\_

We use an electronic medical record system in the office. To allow more effective coordination of your care with others involved in your care (doctors, hospitals, labs, pharmacies, radiology centers, etc.), the electronic record system may be connected to a secure health information exchange. Please place a check mark in the appropriate box:

- I agree to allow my records to be communicated via the internet secure health information exchange in order to aid in coordinating my care.
- I do not want my records to be communicated via the internet secure health information exchange. I understand that this decision means that information that is important to my care may not be communicated as efficiently.

We also utilize TouchMD in the office. TouchMD is an internet-based company that helps us create a more thorough, complete educational experience. By creating a private, password-protected account with TouchMD, you can access diagrams and videos of procedures that are of interest to you. Photographs that we take of you are sent electronically to TouchMD, which then allows you to view the photos in the comfort of your own home or on your mobile device. Please check the appropriate box:

- I agree to use the TouchMD service, allowing me to view diagrams, videos, and my photographs through a password-protected internet connection created by TouchMD.
- I do not want to participate in the use of the TouchMD service. I do not wish to see additional videos or diagrams or my photographs through this system.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



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Please list other physicians involved in your care:

Primary care physician: \_\_\_\_\_  
Ob-gyn physician: \_\_\_\_\_  
Other: \_\_\_\_\_

General or breast surgeon: \_\_\_\_\_  
Medical oncologist: \_\_\_\_\_  
Radiation oncologist: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_  
Have you seen another physician related to this concern? If so, who and when? What was done at that time? \_\_\_\_\_

Have you noticed significant differences between your breasts? For instance, have you noticed that one breast is larger than the other? If you have noticed a difference, please describe: \_\_\_\_\_

Have you had surgery (including breast biopsies) on your breasts before?  Yes  No  
If yes, please list approximate dates of surgery as well as what was done and which surgeon performed the surgery:  
operation #1: date: \_\_\_\_\_ procedure: \_\_\_\_\_ surgeon: \_\_\_\_\_  
operation #2: date: \_\_\_\_\_ procedure: \_\_\_\_\_ surgeon: \_\_\_\_\_  
other: \_\_\_\_\_

Have you undergone radiation therapy to your chest or breast?  Yes  No If yes, when? \_\_\_\_\_

Have you had a mammogram before?  Yes  No  
If yes, when was your last mammogram, and where was it performed? \_\_\_\_\_  
What were the findings of the mammogram? \_\_\_\_\_

While the majority of patients who see Dr. Kunkel concerning their breasts are women, some men also have concerns. The questions in this box are intended for female patients.

What is your bra size? \_\_\_\_\_ Please list the year of birth of any children you have delivered: \_\_\_\_\_  
Did you breast feed any of your children?  Yes  No  Tried but was not successful  Not applicable  
If you breast-fed a child who is currently younger than 2, how long ago did you stop breast feeding? \_\_\_\_\_  
Are you currently breast feeding?  Yes  No  
Do you currently have a discharge from either nipple?  Yes  No If yes, which nipple? \_\_\_\_\_

What is your approximate height? \_\_\_\_\_ feet \_\_\_\_\_ inches What is your approximate weight? \_\_\_\_\_ lbs.  
Tell us a little about your weight:  stable for a long time  gained/lost more than 20 pounds over the last year  
Are you allergic to anything?  No  Yes If yes, what? \_\_\_\_\_  
Are you currently using a nicotine product like cigarettes, cigars, e-cigarettes, nicotine gum/patch, or Juul?  Yes  No  
Have you ever used nicotine products like cigarettes, cigars, e-cigarettes, nicotine gum/patch, or Juul?  Yes  No  
If yes, please tell us about what you have used and for how long: \_\_\_\_\_

Please list medications, vitamins and herbal supplements that you take:

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any illnesses or conditions YOU have had:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other lung problem
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Blood clots	<input type="checkbox"/> HIV
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke/seizure
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Cancer (list): _____		
<input type="checkbox"/> Other medical issues: _____		

Please place a mark by any surgical procedures you have had, and list the approximate year:

<input type="checkbox"/> Cesarean section _____	<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> Tubal ligation _____
<input type="checkbox"/> Surgery on ovaries _____	<input type="checkbox"/> Thyroid surgery _____	<input type="checkbox"/> Tonsillectomy _____
<input type="checkbox"/> Hernia repair _____	<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> Gallbladder _____
<input type="checkbox"/> Surgery of the heart or chest _____	<input type="checkbox"/> Abdominoplasty _____	<input type="checkbox"/> Liposuction _____
<input type="checkbox"/> Other surgery (list) _____		