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
- ☐ Please list your email address only if you authorize Dr. Kunkel and the office staff to communicate with you by email: _____
- ☐ 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

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: _____ General or breast surgeon: _____
Ob-gyn physician: _____ Medical oncologist: _____
Other: _____ Radiation oncologist: _____

What is the reason for your visit? _____
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:

[ ] Diabetes [ ] High blood pressure [ ] Heart problems
[ ] Mitral valve prolapse [ ] Asthma [ ] Other lung problem
[ ] Bleeding disorder [ ] Blood clots [ ] HIV
[ ] Liver disease [ ] Kidney disease [ ] Stroke/seizure
[ ] Autoimmune disorder [ ] Fibromyalgia
[ ] Cancer (list): _____
[ ] Other medical issues: _____

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

[ ] Cesarean section _____ _____ _____
[ ] Surgery on ovaries _____
[ ] Hernia repair _____
[ ] Surgery of the heart or chest _____
[ ] Hysterectomy _____
[ ] Thyroid surgery _____
[ ] Appendectomy _____
[ ] Abdominoplasty _____
[ ] Tubal ligation _____
[ ] Tonsillectomy _____
[ ] Gallbladder _____
[ ] Liposuction _____
[ ] Other surgery (list) _____