thebreastcentre.com.au

CONFIDENTIAL PATIENT REGISTRATION, BREAST HEALTH QUESTIONNAIRE and FEE POLICY FORM

Please return completed form by email to SVPEM.TheBreastCentre@svha.org.au by fax to 03 9928 6260, or bring to your appointment

The Breast Centre at St Vincent's Private Hospital East Melbourne
Suite 92, Level 9, 166 Gipps Street, East Melbourne ,VIC 3002
Tel: 03 9928 6261 Fax: 03 9928 6260 Email: SVPEM.TheBreastCentre@svha.org.au

SECTION 1: PERSONAL DETAILS

Title: Ms ◯ Miss ◯ Mrs ◯ Mr ◯ Dr ◯ Other (Specify) _____

Given Name(s): _____ Preferred Name: _____

Surname: _____ Age: _____ Date of Birth: (DD / MM / YYYY): / /

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

Occupation: _____

SECTION 2: CONTACT & PRIVACY PERMISSIONS

Home Phone: _____ Mobile Phone: _____

Email Address: _____

* May we leave a voicemail message on your mobile phone? Yes ◯ No ◯ N/A ◯

* May we send you SMS appointment reminders? Yes ◯ No ◯ N/A ◯

* May we email you regarding your clinical care and follow up recalls? Yes ◯ No ◯ N/A ◯

SECTION 3: CLINICAL REFERRALS & EMERGENCY CONTACT

General Practitioner (GP): _____ Clinic Name: _____

Referring Doctor (if not GP): _____ Clinic Name: _____

Emergency Contact- Name: _____ Relationship: _____ Mobile: _____

SECTION 4: HEALTH FUND & BILLING DETAILS

Medicare Number: _____ Ref No: _____ Expiry Date: _____/_____

Private Health Insurance Fund: _____ Membership No: _____

Veterans' Affairs (DVA) Number: _____

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SECTION 5: REPRODUCTIVE HEALTH

*Menopausal Status: ◯ Pre-menopausal ◯ Peri-menopausal ◯ Post-menopausal ◯ Unknown Date or Year of Last Period _____

*Are you currently pregnant or breastfeeding? ◯ Yes ◯ Do you have children? ◯ Yes ◯ No Age at first child: _____

*Are you taking: HRT: ◯ Yes ◯ No If yes, year started _____ Oral Contraceptive Pill: ◯ Yes ◯ No

*Have you had a hysterectomy? ◯ Yes ◯ No If yes, were your ovaries removed? ◯ Yes ◯ No ◯ Don't Know

SECTION 6: BREAST HEALTH AND MEDICAL HISTORY

*Have you had a mammogram in the past? ◯ Yes ◯ No If yes, approx date/year of most recent previous mammogram?

*Do you have breast implants? ◯ Yes ◯ No

*Have you had any prior breast surgery? ◯ Yes ◯ No If yes, which breast? ◯ Right ◯ Left ◯ Both

*Have you ever had breast cancer in the past? ◯ Yes ◯ No If yes, which breast? ◯ Right ◯ Left ◯ Both

*Smoking History: ◯ Never ◯ Given Up ◯ Occasionally ◯ Current

*Height (cm): _____ Weight (kg): _____

Current Medications:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Drug Allergies: ◯ Nil Known ◯ Yes (Please list below).

Allergies: _____

Significant Medical Conditions (Check all that apply):

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Taking Blood Thinners

Other Conditions: _____

SECTION 7: FAMILY & GENETIC HISTORY

* Do you have a family history of breast or ovarian cancer? ◯ Yes ◯ No ◯ Unknown

* Are you of Ashkenazi Jewish ancestry? (this may be relevant with respect to your genetic risk) ◯ Yes ◯ No

If yes to family history, please detail below:

1. Relative: _____ Age at Diagnosis: _____ Cancer: ☐ Breast ☐ Ovarian ☐

2. Relative: _____ Age at Diagnosis: _____ Cancer: ☐ Breast ☐ Ovarian ☐

3. Relative: _____ Age at Diagnosis: _____ Cancer: ☐ Breast ☐ Ovarian ☐

SECTION 8: ACKNOWLEDGEMENT

Our Breast Care Nurse is routinely present during consultations to provide clinical support. Please notify reception staff prior to your appointment if you prefer a nurse not to be present.

Patient Signature; _____. Date: ____/____/_____

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