THE SURGICAL CLINIC
OF CENTRAL ARKANSAS
INFORMATION FOR CASE HISTORY FILE

DATE: _____ **(PLEASE COMPLETE ALL ITEMS. PLEASE PRINT)**

PATIENT INFORMATION

PATIENT'S NAME: _____ SS#:_____
First Middle Last

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED EMAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ ALT. PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ BUS. PHONE: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

SPOUSE INFORMATION

NAME: _____ SS#:_____ D.O.B.:_____

EMPLOYER: _____ WORK PHONE: _____

PARENT INFORMATION (This section applies only if the patient is a minor & the parent is financially responsible.)

NAME: _____ SS#:_____ D.O.B.:_____

EMPLOYER: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE: _____

DOCTOR INFORMATION

☐ OB/GYN NAME & ADDRESS: _____ OB/GYN PHONE: _____

☐ FAMILY DOCTOR'S NAME &ADDRESS: _____ PHONE: _____

☐ OTHER M.D'S NAME & ADDRESS: _____ PHONE: _____

Please check the Physicians that you want a letter sent to

EMERGENCY CONTACT INFORMATION (Please list nearest relative not living at the same address as the patient.)

Relative's Name & Address: _____

Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

INSURANCE COMPANY NAME: _____ INSURANCE PHONE NUMBER: _____

CLAIMS ADDRESS: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBERS SS#: _____ SUBSCRIBERS D.O.B: _____ EMPLOYERS NAME: _____

SECONDARY INSURANCE CARRIER

INSURANCE COMPANY NAME: _____ INSURANCE PHONE NUMBER: _____

CLAIMS ADDRESS: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBERS SS#: _____ SUBSCRIBERS D.O.B: _____ EMPLOYERS NAME: _____

PHARMACY RELEASE

I agree that THE SURGICAL CLINIC OF CENTRAL ARKANSAS may request and use my prescription medication history from other healthcare providers or Third party pharmacy benefit payors for treatment purposes.

Signature: _____ Date: _____

I hereby authorize payment directly to **The Surgical Clinic of Central Arkansas,** 9500 Kanis Rd, Suite 501, Little Rock, AR, 72205, of the medical benefits herein specified and otherwise payable to me, but not to exceed the clinic's regular charges for this period of treatment. I understand that I am financially responsible for the charges not covered by this authorization.

Authorization to Release Information: I hereby authorize **The Surgical Clinic of Central Arkansas,** and any other physicians or hospitals that have records, to release information requested by my insurance company in order to pay this claim.

Signature: _____ Date: _____

I give my consent to receive automated phone calls from The Surgical Clinic of Central Arkansas on my mobile phone.

Signature: _____ Date: _____

THE SURGICAL CLINIC
OF CENTRAL ARKANSAS

NAME: _____ AGE: _____ DATE: _____

One of our most important goals during your visit is to instruct you regarding breast disease in general and to answer any questions you may have specifically.

Please list why you are here and what questions we might help you with.

_____

_____

YES NO

☐ ☐ Do you have a family history of breast cancer? Relation to you _____

Age they were diagnosed if known _____

☐ ☐ Do you have a family history of any other type of cancer? (Uterine, ovarian, colon, etc.)

☐ ☐ Do you have a personal history of cancer? What kind? _____

Age you were diagnosed _____

☐ ☐ Do you do monthly breast self-examinations?

☐ ☐ Do you have yearly mammograms?

PERSONAL HISTORY

_____ Age of first period

_____ Age at menopause and/or

Age of last period

_____ Date of last period

_____ Age of hysterectomy

_____ So you still have ovaries?

(One or both)

_____ Age of first pregnancy

_____ Number of pregnancies

_____ Number of live births

_____ Did you breast feed

Number of children & ages:

____ Male(s) Age(s) _____

____ Female(s) Age(s) _____

What size bra do you wear? _____

MEDICAL HISTORY

Please list any medical conditions that you might have (such as diabetes, hypertension, heat condition, heart attack, thyroid, seizures, blood disorders, etc.) _____

_____

_____

Do you have any prosthesis? (Total knee, hip, heart valve etc.) _____

Do you have a mitral valve prolapse? _____ Do you require antibiotics prior to surgery? _____

SURGICAL HISTORY

Please list all previous surgeries and dates other than breast. _____

_____

_____

Please list all previous breast surgeries, dates, and diagnosis. _____

_____

_____

Did you have any problems with anesthesia? (nausea, sensitivity to any of the medications, etc.) _____

_____

IMPLANTS:

What type of implants do you have? _____

When did you have the implants placed? _____

Who performed the augmentation and the date? _____

MEDICATIONS

Please list current medications:

MEDICINE	DOSAGE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken hormones or birth control pills? □ Yes □ No

Type	Dosage	How long
_____	_____	_____
_____	_____	_____

Do you take aspirin or other "over the counter" medicines regularly? Please list all medications.

_____

_____

_____

Do you drink alcohol? □ Yes □ No Approximately how much per day? _____ How long? _____

Do you or have you smoked in the past? □ Yes □ No Approximately how much per day? _____

How long? _____ Date you stopped smoking? _____

Caffeine intake: Approximately how much per day?

Coffee _____ Tea _____ Colas _____ Chocolate _____

Please list all allergies to medications that you have and your reaction to the medications.

_____

_____

_____

_____

This information will be used in statistical form for research purposes. You will never be identified by name. If you agree to have this data (as well as any operative or pathology findings) included in our research to win the war on breast cancer please sign below.

Signature: _____ Date: _____