Patient Name:_____ Today's Date: _____

Patient Date of Birth:_____ Appointment with: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
X Y N	*EXAMPLE: BREAST CANCER*	45	------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
Y N	BREAST CANCER							
Y N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
Y N	UTERINE/ ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
Y N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

Y N Are you of (Ashkenazi) Jewish descent?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain)*

To Be Completed by HealthCare Provider:

Case Discussed: Y N

Patient Accepted: _____ Patient Declined: _____

NEW JERSEY HEALTH NETWORK, LLC ANJEANETTE T. BROWN, M.D.

PATIENT REGISTRATION (PLEASE PRINT FIRMLY AND CLEARLY)

NAME_____ SS #_____

(last) (first) (middle initial)

HOME PHONE (____) _____ CELL PHONE (____) _____

E MAIL ADDRESS_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BIRTHDATE_____ SEX MALE_____ FEMALE_____

SINGLE___ MARRIED___ WIDOWED___ SEPARATED___ DIVORCED___ SIGNIFICANT OTHER _____

ETHNICITY_____ RACE_____ LANGUAGE_____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ PHONE_____

EMERGENCY CONTACT_____ RELATIONSHIP_____ PHONE_____

EMERGENCY CONTACT_____ RELATIONSHIP_____ PHONE_____

PHARMACY NAME_____ PHONE_____

REFERRING PHYSICIAN_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID #_____

SUBSCRIBER_____ DOB_____ SS#_____

RELATIONSHIP_____

SECONDARY INSURANCE_____ ID #_____

SUBSCRIBER_____ DOB_____ SS #_____

The undersigned certifies that I (or my dependent) have insurance coverage as stated above and assign directly to New Jersey Health Network all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 6%, court costs, and attorney fees as allowed by law.

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

RELATIONSHIP TO PARTY_____

NEW JERSEY HEALTH NETWORK, LLC

DR. ANJEANETTE T. BROWN

2500 ENGLISH CREEK AVENUE, EGG HARBOR TOWNSHIP, NJ 08234

PHONE (609) 568-5606 FAX (609) 568-5877

ALLERGIES

Are you allergic to any medications? ☐ *yes* ☐ *no*

**if so, please list any medications to which you have an allergic reaction and the type of reaction:*

Are you allergic to latex? ☐ yes ☐ no

MEDICATIONS

Please list any medications you are now taking (include name, dosage, and frequency)

*NAME OF PHARMACY*_____

*ADDRESS AND PHONE*_____

MEDICAL HISTORY

Do you currently have, or have you had any of the following?

High Blood Pressure?	☐ Yes ☐ No ☐ Do not know
Heart Attack?	☐ Yes ☐ No ☐ Do not know
High Cholesterol?	☐ Yes ☐ No ☐ Do not know
Been treated for Heart failure? (You may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping well)	☐ Yes ☐ No ☐ Do not know
A stroke, cerebrovascular accident (CVA) blood clot or bleeding in the brain, or transient ischemic attack (TIA)?	☐ Yes ☐ No ☐ Do not know
If yes, do you have difficulty moving an arm or leg as a result of a stroke or cerebrovascular accident?	☐ Yes ☐ No ☐ Do not know
Asthma, Emphysema, chronic bronchitis, or chronic obstructive lung disease (COPD)	☐ Yes ☐ No ☐ Do not know
If yes, do you take medicine for your condition (either on a regular basis or just for flare ups?)	☐ Yes ☐ No ☐ Do not know
Stomach ulcers or peptic ulcer disease ?(PUD)	☐ Yes ☐ No ☐ Do not know
If yes, was this condition diagnosed by endoscopy (where a doctor looks into your stomach through a scope) or an upper GI or barium swallow study?	☐ Yes ☐ No ☐ Do not know
Diabetes or high blood sugar?	☐ Yes ☐ No ☐ Do not know
If yes, is it treated by modifying your diet?	☐ Yes ☐ No ☐ Do not know
If yes, is it treated by medications taken by mouth?	☐ Yes ☐ No ☐ Do not know
If yes, is it treated by insulin injections?	☐ Yes ☐ No ☐ Do not know
Problems with your kidneys	☐ Yes ☐ No ☐ Do not know
Autoimmune Disease such as Rheumatoid arthritis, Lupus, or other form of autoimmune disease?	☐ Yes ☐ No ☐ Do not know
Lupus or Polymyalgia rheumatic?	☐ Yes ☐ No ☐ Do not know
Alzheimer's Disease, or another form of dementia?	☐ Yes ☐ No ☐ Do not know
Cirrhosis, or serious liver damage?	☐ Yes ☐ No ☐ Do not know
HIV/AIDS	☐ Yes ☐ No ☐ Do not know
Other medical condition not listed (other than cancer)	☐ Yes ☐ No ☐ Do not know

MEDICAL HEALTH QUESTIONNAIRE

DATE _____/_____/_____

NAME (LAST, FIRST, MI)_____DOB_____

NAME AND ADDRESS OF PRIMARY CARE OR REFERRING PHYSICIAN

_____

_____

_____

_____

REASON FOR SEEKING CARE

1. Have you been diagnosed with breast cancer recently or are you here to seek treatment for breast cancer? □ YES □ NO
2. What was the very FIRST problem that occurred which prompted you to seek medical care? *Check one*
   - □ *abnormal mammogram*
   - □ *lump in breast found by self*
   - □ *lump in breast found by clinician*
   - □ *armpit or axillary mass*
   - □ *inverted nipple*
   - □ *bloody discharge from nipple*
   - □ *breast pain or discomfort*
   - □ *other (please specify)* _____

At approximately what date did this symptom (including abnormal mammogram) become apparent to you?

_____

3. Were there any other problems? *Check all that apply*
   - □ *abnormal mammogram*
   - □ *lump in breast found by self*
   - □ *lump found by clinician*
   - □ *armpit or axillary mass*
   - □ *inverted nipple*
   - □ *bloody discharge from nipple*
   - □ *breast pain or discomfort*
   - □ *other (please specify)*_____
4. When was the date of your last mammogram? _____

GYNECOLOGIC HISTORY

5. At what age did you have your first period? _____

6. How many times have you been pregnant? _____

7. How many live births have you had? _____

   a. If you have children, what was your age at your first full term pregnancy? _____

   b. If you have children, what was your age when you had your last full term pregnancy? _____

8. Have you ever breast fed? □ YES □ NO

   a. If yes, how many months (in total) have you breast fed? _____months

   b. If yes, how many years (or months) ago did you last breast feed? _____months/years

   please circle one

9. Have you had a menstrual period within the last six months?

   □ YES □ No

   □ Yes, natural menstrual periods or menstrual periods on birth control

   □ Yes, menstrual periods on hormone replacement therapy

   □ Unknown

   a. If yes, when was your last menstrual period? _____/_____/_____

   b .If no, at what age did you stop having periods?_____

   c. If no, why did you stop having periods? *Check one*

   □ pregnancy and/or breastfeeding □ both ovaries removed, no hysterectomy

   □ natural menopause □ chemotherapy/radiation therapy hormone therapy

   □ hysterectomy with ovaries left in □ medical condition associated with ovarian failure

   □ hysterectomy/ both ovaries removed □ hormone replacement therapy

   □ hysterectomy/unsure of ovaries □ other *please specify*_____

10. Have you ever used, or do you intend to use, post menopausal hormone replacement therapy?

   □ No, never

   □ Yes, currently ----------When did you start therapy (month/year)? ____/_____

   □ Yes, in the past----------When did you last use hormones (month/year)?_____/_____

a. If yes, how many total years (or months) have you used hormone replacement?_____

months/years

b. What form(s) of hormone do/did you take?

□ pill □ estrogen only

□ patch □ progesterone only

□ cream □ combination estrogen and progesterone

□ other_____ □ do not know

11. Do you use, or have you ever used birth control pills?

□ No, never

□ Yes, currently

□ Yes, in the past---------When did you last use birth control pills (month/year)?

a. If yes, how many total years (or months) have you used birth control pills? _____month/years

circle one

12. Have you ever used fertility pills? □ Yes □ No

a. If yes, have you ever used Clomiphene (i.e. Serophene, Clomid)? □ Yes □ No □ Do not know

b. If yes, have you used an injectable hormone (i.e. hMG, Gonal-F, Follitism)?

□ Yes □ No □ Do not know

FAMILY HISTORY

Please include only blood relatives, both living and deceased.

13. How many sisters do you have? _____ 14. How many brothers? _____

15. How many daughters? _____ 16. How many sons? _____

17. Do you have any blood related family relatives who have been diagnosed with cancer or other medical conditions? If yes, please use the chart below to indicate their relationship to you, the type of cancer they have, their age at diagnosis, and their current age if alive or their age at death.. Please provide your best estimate for ages.

BLOOD RELATIVE	MATERNAL OR PATERNAL	CANCER TYPE	AGE AT CANCER DIAGNOSIS	OTHER MEDICAL CONDITIONS	CURRENT AGE IF ALIVE	AGE AT DEATH IF PASSED

SMOKING AND ALCOHOL HISTORY

18. Have you ever or do you currently smoke?

□ Yes, but only in the past If yes, at what age did you start smoking?_____

□ Yes, currently If yes, at what age did you stop smoking?_____

□ No, never

a. If yes, on average, how many packs per day did you smoke, or do you currently smoke? *Check one*

□ less than ½ pack per day □ 1 ½ pack per day

□ ½ pack per day □ 2 packs per day

□ 1 pack per day □ more than 2 packs per day

19. Have you ever or do you currently drink alcohol?

□ Yes, but only in the past

□ Yes, currently

□ No, never

a. How many alcoholic beverages (beer, wine, mixed drinks, etc.) do you consume weekly? *Check one*

PHYSICAL ACTIVITY

20. Which option below best describes your level of physical activity OVER THE PAST WEEK? *Check one.*

□ fully active, able to carry on all usual activities without restriction
□ restricted in strenuous activity: can walk, able to carry out light housework
□ can walk and take care of self: up more than ½ day
□ need some help in taking care of self; spend more than ½ day in bed or chair
□ cannot take care of self at all and spend all my time in bed

PATIENT BACKGROUND INFORMATION

21. Select what best describes your educational status. *Check one*

□ some grade school □ some college or associate's degree
□ some high school □ college graduate
□ high school graduate □ graduate or professional school
□ vocational/ technical school □ other *please specify*_____

22. What is your current employment status? *check one*

□ homemaker □ on medical leave
□ employed 32 hours or more/week □ disabled

- ☐ employed less than 32 hours/week
- ☐ full-time student
- ☐ part-time student
- ☐ part-time student, also employed less than 32 hours/week
- ☐ unemployed and/or seeking work
- ☐ retired
- ☐ other *please specify*_____

23. Are you of Spanish/Hispanic origin?

☐ yes ☐ no ☐ do not know

24. Select what best describes your racial background. *Check one*

Definitions from Federal Government's Office of Management and Budget

☐ American Indian or Alaska Native	Have origins in any of the original peoples of North and South America (including Central America) and maintain tribal affiliations or community attachment
☐ Asian	Have origins in any of the original peoples of the far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam
☐ Black or African American	Have origins in any of the original peoples of Africa; including Haitian
☐ Native Hawaiian or other Pacific Islander	Have origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
☐ White	Have origins in any of the original peoples of Europe, the Middle East or North Africa

25. Were any of your grandparents of Ashkenazi Jewish background? (from France, Germany, Eastern Europe, or Russia)

PAST MEDICAL HISTORY

26. Please list all cancers with which you have been diagnosed, the year you were diagnosed, and the treatment(s) received:_____

_____

_____

_____

_____

PAST SURGERY/OPERATIONS

27. Please list in chronological order (include type, reason, and approximate year)

TYPE OF SURGERY HOSPITAL/CITY YEAR

_____

_____

_____

Year	Which Breast? (Right or Left)	Needle Core Biopsy or Excisional Biopsy	Diagnosis

PAST BREAST SURGERIES

28. How many previous breast biopsies have you had, including any needle core and excisional biopsies?
_____*Do not include cyst aspirations*

REVIEW OF SYSTEMS

GENERAL

- ☐ Fever
- ☐ Night Sweats
- ☐ Generalized Weakness
- ☐ Weight Loss
- ☐ Chills
- ☐ Fatigue
- ☐ Change in Appetite

EYES

- ☐ Wear Contacts/Glasses
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Change in Vision
- ☐ Irritation
- ☐ Redness
- ☐ Yellowing of eyes
- ☐ Color Blindness

EARS/NOSE/THROAT

- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Ear Drainage
- ☐ Earaches
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Snoring
- ☐ Pain in Mouth/Throat
- ☐ Hoarseness
- ☐ Change in Voice
- ☐ Facial Trauma
- ☐ Color Blindness

LUNGS

□ Cough □ Phlegm □ Coughing up Blood □ Pleurisy/Chest Pain
□ Pneumonia □ Asthma □ Wheezing □ Difficulty in breathing w/ exertion
□ Emphysema □ Chronic Bronchitis □ Shortness of Breath □ Abnormal breathing sound

HEART/VASCULAR

□ Chest Pain □ Chest pressure/Discomfort □ Palpitations □ Irregular Heartbeat
□ Fainting or near fainting □ Difficulty breathing while lying flat □ SOB/Coughing at night
□ Swelling of legs □ Chest pain while walking □ Facial Trauma

GASTROINTESTINAL

□ Difficulty or Pain w/ swallowing □ Reflux symptoms □ Vomiting □ Da rk / Bloody Stools
□ Constipation □ Yellowing of Skin □ Indigestion □ Nausea
□ Change in Bowel habits □ Diarrhea □ Abdominal Pain □ Vomiting Blood

GENITOURINARY

□ Frequent Urination □ Needing to get up at night to urinate □ Urinary hesitancy or retaining urine
□ Painful Urination □ Urinary Incontinence □ Decreased urine stream
□ Blood in the urine □ Vaginal/Penal Discharge □ Skin abnormalities on genitals

SKIN/HAIR/NAILS

□ Rash □ Itching □ Skin Lesions □ Dry Skin
□ Change in Skin Color □ Change in Mole

HEMATOLOGIC/LYMPHATIC

□ Bruise Easily □ Blood Transfusion (date___/___/___) □ Bleed Easily
□ Persistant swollen glands or lymph nodes

MUSCULOSKELETAL

□ Muscle Aches/Pain □ Joint Pain □ Stiff Joints □ Neck Pain
□ Back Pain □ Bone Pain

HEAD AND NERVOUS SYSTEM

□ Migraines or severe headaches □ Seizure/Epilepsy □ Speech Problems
□ Coordination problems □ Trembling/tremors □ Fainting/blackouts □ Dizziness
□ Memory problems □ Loss of sensation/numbness □ Problem walking □ Weakness
□ Tingling or burning in hands or feet

PSYCHIATRIC/SOCIAL

□ Abusive relationship □ Bipolar □ Sleep Disturbance □ Anxiety
□ Depression □ Feeling of despair

ENDOCRINE

□ Poor/slow wound healing □ Weight loss/gain □ Fertility or hormone problems
□ Cold intolerance □ Thyroid disease

ALLERGIC/IMMUNOLOGIC

□ Hives □ Hay Fever □Angioedema (Rapid throat swelling) □ Anaphylaxis

HIPPA – NOTICE OF PRIVACY PRACTICES – effective 4/14/2013

To our Patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPPA). Effective April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of a U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

OUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications – You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operation. Additionally, you have the right to restrict our disclosure of your information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to the office to the attention of your physician. If you have any questions you may call the office manager at 609-568-5606.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office to the attention of your physician. If you need further information, call the office manager at 609-568-5606. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office, Attn: Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office manager at 609-568-5606.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices by signing below.

_____ _____

SIGNATURE DATE

_____

PLEASE PRINT NAME

LAB WORK AND TEST RESULTS

I hereby give permission for the results of any and all lab work and test results to be:

_____ left on my answering service at my home and/or given to my spouse OR

_____ given to _____

PLEASE PRINT

_____ I DO NOT give permission to leave messages on my answering machine or with someone at the number provided.

PATIENT PERMISSION FORM

The following persons have my permission to pick-up prescriptions, drug samples, referrals or documentation being provided to me through this office. I understand that these persons must provide identification prior to receipt of the above.

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

APPOINTMENTS

It is our office policy to confirm your scheduled appointment via phone calls to the number provided by you. The calls are made two days before the day of your appointment. Your signature below allows us to leave a message with someone at the number provided or on an answering system at that number.

_____ I DO give permission to leave or give a message confirming an upcoming appointment.

_____ I DO NOT give permission to leave or give a message confirming an upcoming appointment.

(We will mark your account and make every effort to reach you directly)