COMPREHENSIVE BREAST CENTER OF AZ
LISE C. WALKER, M.D. AND VICTOR J. ZANNIS, M.D.
2525 W. GREENWAY ROAD, SUITE 130
PHOENIX, AZ 85023
PHONE (602) 942-8000 FAX (602) 942-8025

Patient_____
Last name, First MI Nickname

Referred for consultation by:_____

Other physicians you would like included on correspondence:_____

Patient Street/Mailing Address_____Apt/Unit#_____

City, State_____, _____ **ZIP**_____ Preferred Phone Contact:
Home Phone (10 digit) (____)_____
Cell Phone (10 digit) (____)_____

Birthdate:__/__/__ Age__ Social Sec#_____
E-mail address_____

Single__ Married__ Divorced__ Widow__ Partnered__ Race_____ Ethnicity_____
Patient Employed By_____ Business Phone (_____)_____

Spouse Name_____ Birthdate____/____/____
Spouse's Employer Name_____ Business/Cell Phone (____)_____
(or Emergency Contact Name & Phone)

(PLEASE INDICATE IF YOU HAVE MEDICARE INSURANCE!)
Name of Primary Insurance_____ Name of Insured_____
Relationship to Patient_____ Group #_____ ID# or SSN:_____

Names of Secondary Insurance_____ Name of Insured_____
Relationship to Patient_____ Group #_____ ID# or SSN:_____

Pharmacy Phone/Name/Location_____

Assignment and Release: I agree that this office may release my records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physicians participation with my health plan. I authorize my insurance benefits to be paid directly to my physician and I realize that I am financially responsible for any non-covered services or expenses.

____Please initial if OK to use this form for release to request records not provided for today's consultation. _____ Signature Date

I acknowledge that I have received a copy of the office's Notice of Privacy Practices. _____ Signature

_____ Printed name if signed on behalf of patient

_____ Relationship (parent, legal guardian, personal representative, etc.)

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

Current Medications (Names Only)	
1._____	7._____
2._____	8._____
3._____	9._____
4._____	10._____
5._____	11._____
6._____	12._____

Past Medical History (Fill in circle if you have history of this)			
Acid Reflux of Stomach (GERD)	O	High Cholesterol or High Lipids	O
Acute Myocardial Infarction (Heart Attack)	O	Hypertension (High Blood Pressure)	O
Anemia	O	Hepatitis of the Liver	O
Arthritis	O	Hyperthyroidism (High Thyroid)	O
Asthma	O	Hypothyroidism (Low Thyroid)	O
Irregular Heartbeat	O	HIV Positive	O
Autoimmune Disease	O	Kidney Failure	O
Blood Dyscrasias (Blood Clotting Disorder)	O	Kidney Stones	O
Cancer, Breast	O	Multiple Sclerosis	O
Cancer, Ovarian	O	Obesity	O
Cancer, Other Type:_____	O	Osteoporosis	O
Carotid Stenosis (Blockage In Neck)	O	Parkinsons Disease	O
Cardiomyopathy (Enlarged Heart)	O	Peripheral Artery Disease	O
Cirrhosis of the Liver	O	Renal Insufficiency (Kidney Disease)	O
Congestive Heart Failure	O	Rheumatic Heart Disease	O
Deep Vein Thrombosis	O	Sleep Apnea	O
Diabetes	O	Seizures	O
Emphysema, COPD	O	Other Medical Problem: Type:_____	O
Heart Murmur	O	Other Medical Problem: Type:_____	O
Herniated Back Disc	O		

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

Allergies to Medications
____No Known Allergies ____ Penicillin ____Sulfa ____Codeine
Other medication allergies: 1._____ 2._____ 3._____

Surgical History			
Appendectomy (Appendix Removed)	O	Cholecystectomy (Gallbladder Removal)	O
Aortic/Mitral Heart Valve Replacement	O	Coronary Artery Bypass Graft/Cardiac Stents	O
Aortobifemoral Bypass	O	Hysterectomy, One or Both Ovaries Left In	O
Bladder Surgery	O	Hysterectomy, Both Ovaries Removed	O
Brain Surgery	O	Lung Resection	O
Breast Biopsy	O	Nephrectomy (Kidney Removed)	O
Breast Lumpectomy	O	Pacemaker, Cardiac	O
Breast Implant	O	Total Joint Replacement Type:_____	O
Breast Mastectomy	O	Transplant (Kidney, Heart, or Lung)	O
Breast Reconstruction	O	Other Surgery Type:_____	O
Carotid Endarterectomy	O	Other Surgery Type:_____	O

Family History	
Who in your family has had breast cancer? (e.g, mother, maternal aunt, paternal grandmother)	
Who in your family has had ovarian cancer?	
Are you Ashkenazi Jewish? (We ask since this subgroup has higher incidence of breast cancer.)	O Yes O No

Social History	
How much alcohol do you consume a week?	
Do you smoke? O Yes O No Former smoker? O Yes O No	

Breast Care Center – Medical History Form

Name: _____ Date of Birth: _____

General/Constitutional	
Bone Pain	O
Fatigue	O
Fever	O
New Onset Headache	O
Night Sweats	O
Ophthalmic	
Blurred Vision	O
Respiratory	
Blood In Sputum	O
Cough	O
Shortness Of Breath At Rest	O
Shortness Of Breath With Exertion	O
Wheezing	O
Breast	
Bloody Nipple Discharge	O
Breast Lump	O
Breast Pain	O
Breast Swelling	O
Nipple Discharge	O
Red Skin	O
Nipple Retraction	O
Cardiovascular	
Heart Attack	O
Heart Murmur	O
Swelling In Legs	O
Chest Pain At Rest	O
Chest Pain With Exertion	O
Dizziness	O
Irregular Heartbeat	O
Palpitations	O
Weakness	O

Gastrointestinal	
Jaundice	O
Abdominal Pain	O
Constipation	O
Diarrhea	O
Exposure to Hepatitis	O
Nausea	O
Vomiting	O
Hematology	
Easy Bruising	O
HIV	O
Prolonged Bleeding	O
Recent Transfusion	O
Swollen Glands	O
Skin	
Rash	O
Neurologic	
Balance Difficulty	O
Difficulty Speaking	O
Fainting	O
Seizures	O
Tingling/Numbness	O

Name: _____ Date of Birth: _____

OB / GYN History	
How old were you when you started your period?	
How old were you when you experienced menopause?	
How many pregnancies have you had?	
How many births?	
How old were you when you had your first child?	
If you have taken oral contraceptives, how many years did you take them?	
If you have taken fertility treatments, how many years did you take them?	
If you have taken hormone replacement therapy medications (e.g.,estrogen), how many years did you take them?	