Walter R. Wolfe, M.D.

Obstetrics and Gynecology

Dominican Plaza
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Jackson, MS 39216
601-200-8201

PATIENT INFORMATION RECORD

(PLEASE PRINT OR WRITE LEGIBLY)

DATE:

PATIENT'S NAME (LEGAL)	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

PATIENT'S ADDRESS	CITY, STATE, AND ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE
EMPLOYER'S STREET ADDRESS	CITY, STATE, AND ZIP CODE	CELL (OPTIONAL)

SPOUSE'S NAME	SPOUSE'S SOC. SEC. #	SPOUSE'S D.O.B.	AGE

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE
EMPLOYER'S ADDRESS	CITY, STATE, AND ZIP CODE	CELL (OPTIONAL)

REFERRED BY
NEAREST RELATIVE NOT LIVING WITH PATIENT

FOR EMERGENCY, CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.
FOR EMERGENCY, CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ PRIVATE PAY ☐ MEDICAID ☐ MEDICARE

In order to control our costs of billing, we request that office visits be paid at the time service is rendered.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plan to Walter R. Wolfe, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and/or complete disability, insurance or FMLA forms. I agree to pay court cost and legal fees if account is turned into collections.

COMMUNICATIONS REGARDING MY ACCOUNTS:

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

SIGNED: ______________________________ DATE: ______________________

Risk Assessment for Hereditary Breast and Ovarian Cancer Syndrome

Patient Name:________________________ Physician:________________________

Date of Birth:________________________ Date Completed:____________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Self Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

	Self	Family Member	Age of Diagnosis
Y N Breast cancer at the age 50 or younger	____	__________	______
Y N Breast cancer over the age of 50	____	__________	______
Y N Bilateral Breast Cancer or Breast Cancer twice in the same person	____	__________	______
Y N Ovarian Cancer	____	__________	______
Y N Male breast cancer	____	__________	______
Y N Triple negative breast (ER,PR,HER2-pathology)	____	__________	______
Y N Pancreatic cancer	____	__________	______
Y N Ashkenazi Jewish ancestry	____	__________	______
Y N Uterine (endometrial cancer)	____	__________	______
Y N Colorectal cancer	____	__________	______
Y N Ovarian, stomach, urinary tract, brain or small bowel cancer	____	__________	______

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain:______________________________

____

Patient's Signature Date

*For a better understanding of triple negative breast cancer please ask your healthcare provider.

FOR OFFICE USE ONLY

____ Candidate for further risk assessment and/or genetic testing
____ Information given to patient to review
____ Follow-up appointment scheduled Date________
____ Patient offered genetic testing
____ Accepted
____ Declined

____
Healthcare Professional's Signature Date

WELCOME!!!!!!! NAME______________________________

Briefly describe the reason for today's visit:

____

When was your last physical exam?__________

When was your last pap smear?__________ Was it normal? ____

Have you ever had an abnormal pap smear?____ When?______

When was your last menstrual period?________

How often do you have your period?________

Are you sexually active?________________

What method of birth control do you use?

____

Have you ever been pregnant? Yes or No

If yes, how many times?________________

How many children do you have?__________

Did you deliver vaginally or by C-Section?

____

Have you ever had a miscarriage, abortion or ectopic pregnancy? Yes or No
If yes, Explain______________________

Have you ever had surgery? Yes or No
If yes, Explain______________________

Have you ever been hospitalized? Yes or No
If yes, Explain______________________

Are you allergic to any medications? Yes or No
If yes, Explain______________________

What Medications (if any) do you take everyday

____

IF YOU HAVE HAD A TUBAL LIGATION
PLEASE PROVIDE THE YEAR __________

Do your parents, grandparents, aunts, uncles, siblings, or children have any of the following?

Cancer	Yes	or	No
Diabetes	Yes	or	No
Heart Disease	Yes	or	No

Anemia	Yes	or	No
Clotting disorder	Yes	or	No
Blood transfusion	Yes	or	No
HIV	Yes	or	No
Breast lump	Yes	or	No
Painful periods	Yes	or	No
Chlamydia	Yes	or	No
Diabetes	Yes	or	No
Endometriosis	Yes	or	No
Genital Warts	Yes	or	No
Gonorrhea	Yes	or	No
Heart disease	Yes	or	No
Lung disease	Yes	or	No
Hepatitis	Yes	or	No
High blood pressure	Yes	or	No
Incontinence	Yes	or	No
Ovarian cysts	Yes	or	No
Hot Flashes	Yes	or	No
Pelvic infection	Yes	or	No
Infertility	Yes	or	No
Thyroid problems	Yes	or	No
Cancer	Yes	or	No
Colposcopy	Yes	or	No
Cryosurgery	Yes	or	No
Laser Surgery	Yes	or	No
Syphilis	Yes	or	No
DES Exposure	Yes	or	No
Epilepsy	Yes	or	No
Kidney Disease	Yes	or	No
Eating Disorder	Yes	or	No

YEARLY RETURN VISIT QUESTIONAIRE

Name________________________________ Date__________

Chart#________

WELCOME BACK!!

We hope you have been well since your last visit with us. Please let us know if you have had any medical problems since your last visit:

____

____

____

What's the name of your pharmacy and its location?

____

What medications (if any) are you presently taking?

____

____

When was your last period (if menstruating)?

____

What type of birth control (if any) are you presently using?

____

Do you have any questions you would like to discuss at this visit?

____

____

Have you seen any other physician(s) since your last visit and why?

____