Walter R. Wolfe, M.D.

Obstetrics and Gynecology

Dominican Plaza
970 Lakeland Drive, Ste 43
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