www.thebreastcentre.com.au

Please complete this form and fax to 03 9928 6260, email to SVPEM.The BreastCentre@svha.org.au or bring to your appointment

CONFIDENTIAL PATIENT REGISTRATION, BREAST HEALTH and FEE POLICY FORMS

The Breast Centre at St Vincent's Private Hospital East Melbourne
Suite 92, Level 9, 166 Gipps Street, East Melbourne VIC 3002
Tel: 03 9928 6261 Fax: 03 9928 6260 Email: SVPEM.The BreastCentre@svha.org.au

TITLE: Mrs ☐ Miss ☐ Ms ☐ Mr ☐ Other (Specify) ☐

GIVEN NAMES:

PREFERRED NAME:

SURNAME:

HOME ADDRESS:

:

DOB:

CONTACT DETAILS:

TELEPHONE: Home

Mobile

(for SMS appointment confirmation/reminders)

EMAIL ADDRESS:

POSTAL ADDRESS: (if different from home address)

MEDICARE NO: /

:

EXPIRY DATE:

PRIVATE HEALTH INSURANCE: ☐ Yes ☐ No

HEALTH FUND:

MEMBERSHIP NO:

EMERGENCY CONTACT:

GIVEN NAMES:

SURNAME:

RELATIONSHIP:

CONTACT DETAILS:
Mobile

GENERAL PRACTITIONER:

REFERRING DOCTOR (if not GP)

We may need to contact you after your appointment.
If you are unavailable may we leave a message?

Mobile phone voicemail

☐ Yes ☐ No. ☐ N/A

May we SMS/text you?

☐ Yes. ☐ No ☐ N/A

May we email you?

☐ Yes. ☐ No ☐ N/A

VETERANS AFFAIRS:

OCCUPATION:

www.thebreastcentre.com.au

The Breast Centre at St Vincent's Private Hospital East Melbourne Breast Health History

Name: _____ DOB: _____ Age: _____

Menopausal Status: Pre ☐ Peri ☐ Post ☐ Unknown ☐

When was your last period ? Date___ Month____ Year_____ Have you had breast cancer in the past? Yes ☐ No ☐

Are you pregnant or breastfeeding ? Yes ☐ No ☐ Do you have breast implants? Yes ☐ No ☐

Have you had any breast surgery in the past? Yes ☐ No ☐ If yes, which breast? R ☐ L ☐ Both ☐

Previous Mammogram: Yes ☐ No ☐ If yes, approximate date: Date ___ Month____ Year _____

Smoking: Never ☐ Given Up ☐ Occasionally ☐ Current ☐

Height: _____ cm Weight: _____ kg

Are you taking: HRT: Yes ☐ No ☐ Year Started_____ Oral Contraceptive Pill : Yes ☐ No ☐

Have you had a hysterectomy? Yes ☐ No ☐ If yes, were your ovaries removed? Yes ☐ No ☐ Don't Know ☐

Do you have a family history of breast or ovarian cancer? Yes ☐ No ☐ Unknown ☐

If yes, please list details: Relative Age at Diagnosis Breast or Ovarian

_____ _____ _____

_____ _____ _____

Are you of Jewish ancestry? (this may be relevant with respect to your genetic risk) Yes ☐ No ☐

Medications- please list:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Drug Allergies: Nil Known ☐ Yes ☐ (Please list) _____ _____ _____

Significant Medical History:

Diabetes ☐ Heart Disease ☐ Blood Thinners ☐ High Blood Pressure ☐

Other _____

Signed: _____ Name: _____

Date: _____

Please Note: Our Breast Care Nurse is routinely present during most consultations. Please advise us prior to going in to your consultation if you would prefer a breast care nurse ***not*** to be present.