

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?

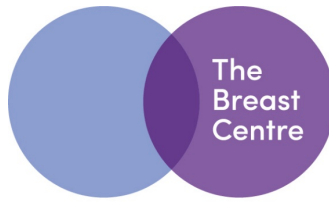
Yes. No N/A

May we email you?

Yes. No N/A

VETERANS AFFAIRS:

OCCUPATION:



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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.