By Your Side LLC
Professional Breast Cancer Consulting & Advocacy

Mary J. Heffernan, MN, ARNP, AOCNP
425.655.9151
muff@my-bys.com
my-bys.com

NEW PATIENT INFORMATION

Today's Date _____ Gender _____ Date of Birth _____ Age _____

Name _____

Address _____

Home Phone _____ Mobile Phone _____

Email _____
(we use email to communicate appointment information and do not send solicited material)

How may we contact your? *(select all that apply)* ☐ Phone ☐ Voice Message ☐ Text ☐ Email ☐ Postal Mail

Primary Concern(s) / Goals for Your Visit Today: _____

Name of Referring Physician / Individual *(if applicable)* _____

MEDICAL HISTORY

Have you ever had any of the following? If so, is it a current problem?

☐ Acid Reflux Disease _____
☐ Arthritis _____
☐ Asthma _____
☐ Anxiety / Depression _____
☐ Blood Clots _____
☐ Blood Disorder _____
☐ Diabetes _____
☐ Cancer (other than breast) _____
☐ Heart Disease / Heart Murmur _____
☐ Hepatitis _____ Type _____
☐ Herpes (cold sore, genital or shingles) _____
☐ High Blood Pressure _____
☐ HIV _____
☐ Migraines / Headaches _____
☐ Sleep Apnea / Snoring _____
☐ Stroke / TIA _____

Have you recently had any of the following?

☐ Abdominal Pain _____
☐ Breast Pain / Skin Changes / Nipple Discharge _____
☐ Changes in Vision / Hearing _____
☐ Chest Pain / Shortness of Breath _____
☐ Fever / Chills / Nausea / Vomiting / Diarrhea _____
☐ Frequent Colds / Sinus Congestion _____
☐ Hot Flashes (impacting sleep or daily life) _____
☐ Lumps in Neck _____
☐ Numbness / Tingling / Cramping in Hands / Feet _____
☐ Recent Hospitalizations (reason/duration) _____
☐ Seizures _____
☐ Skin Rashes / Lumps _____
☐ Unitentional Weight Loss _____
☐ Other _____
_____

Height _____ Weight _____ Age First Menstrual Period _____ Number of Pregnancies _____

Age First Child was Born _____ Age at Menopause _____ Hormone Replacement Therapy *(years taken)* _____

Previous Surgeries *(provide dates)* _____
_____

Drug Allergies & Reactions _____ Latex Allergy ☐ Yes ☐ No

Current Medication(s) & Supplements / Treating What *(dosage)*

_____ _____ _____ _____
_____ _____ _____ _____

Recent Immunizations *(type / year)* _____ _____ _____

Significant Family Medical History / History of Cancer *(include type and age diagnosed if known)*
_____
_____

Have you ever had cancer specific genetic testing? *(type / year)* _____

SOCIAL HISTORY

Relationship/Marital Status

☐ Single

☐ Partnered Spouse/Partner Name _____ ☐ Also Emergency Contact

Children at Home *(ages)* _____ Are you caring for other family members? _____

Other Relationship Status *(if you would like to include in your file)* _____

Emergency Contact _____ Phone _____ Relationship to You_____

Employment Information

Occupation _____ Employer _____ Work Phone _____

Nicotine Use

☐ I am not a smoker.

☐ I no longer smoke regularly. I quit _____ weeks / months / years ago.

☐ I currently smoke _____ a day.

Alcohol Consumption

☐ I never consume alcoholic drinks.

☐ I occasionally consume alcoholic drinks. Approximate drinks per week _____

☐ I regularly consume alcoholic drinks. Approximate drinks per week _____

Exercise / Activity Level _____

I hereby declare that the information provided on this form is true and accurate to the best of my knowledge. I understand that an electronic signature has the same legal effect as aa written signature.

☐ By checking this box and typing my name below, I am electronically signing my health history.

First Name _____ Middle Initial _____ Last Name _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

If requested, I, _____, authorize the following information to be shared.

(Patient Name)

☐ **NO ONE** ☐ **ALL INFORMATION** ☐ Appointment Dates / Times ☐ Test Results ☐ Other _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Regarding the items above, I understand that by signing this form, only the person(s) designated above are allowed to obtain my information and they are only allowed to obtain information regarding the items that I have designated. By checking beside "ALL INFORMATION" I understand that the person(s) listed will be granted access to obtain all of my medical and personal information that By Your Side, LLC has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.