Mount Sinai

MOUNT SINAI SCHOOL OF MEDICINE

Mount Sinai North Shore Medical Group

Mount Sinai The Mount Sinai Hospital of Queens

A Division of The Mount Sinai Hospital

Mount Sinai Diagnostic and Treatment Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

_____

Patient Name

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other,(explain):* _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

- ☐ Acknowledgement subsequently obtained, (see above).

MOUNT SINAI'S COMMUNITY BREAST HEALTH EDUCATION AND SCREENING PROGRAM

We are glad you have agreed to participate in this program. Please complete the following questionnaire. If you need assistance our staff would be happy to help you. Your privacy is important to us. All the information you are providing on this form is confidential.

Insurance Information

* Please note: You do not need health insurance to participate in our program.

What medical insurance do you have?

[ ] Medicaid [ ] Medicare [ ] Other Medical Insurance _____

[ ] None

Personal History

1. Where were you born? _____

2. What is your race or ethnic background?

[ ] African American [ ] Asian [ ] Hispanic/Latina

[ ] White (Non-Hispanic) [ ] Other (specify) _____

Breast Health History

1. Do you have any problems with your breasts now? [ ] Yes [ ] No

If yes, what are the problems? _____

_____

_____

_____

2. Have you had any problems with your breasts in the past? [ ] Yes [ ] No

If yes, what were the problems? _____

_____

_____

_____

3. Have you ever examined your own breasts? [ ] Yes [ ] No
If yes, how often do you examine them? _____
Has anyone ever taught you how to examine your breasts? [ ] Yes [ ] No

4. Has a doctor or nurse ever examined your breasts? [ ] Yes [ ] No
If yes, when was your last breast exam? _____

5. Have you ever had a mammogram? [ ] Yes [ ] No
If yes, when was your last mammogram? _____
Where did you go for the mammogram? _____

6. Have you ever had a needle biopsy of your breast?
(Fluid taken out of your breast with a needle) [ ] Yes [ ] No

Have you ever had a biopsy of your breast? [ ] Yes [ ] No

Have you ever had any other type of breast surgery? [ ] Yes [ ] No
If yes, what type? _____

7. Have you ever been diagnosed with breast cancer? [ ] Yes [ ] No
If yes, when? _____
What type of treatments did you have? _____
_____

8. Have any of your immediate family members had breast cancer?
[ ] Yes [ ] No
If yes, who? _____

Thank you for filling out this information.

Screening Site:_____ Date: _____

Patient Name: _____ Age: _____
Address: _____ Phone Number: _____
_____

Physician Screening Form

I: Medical History

PMH : _____

_____

Medications: _____

_____

Allergies: _____

Surgeries: _____

GYN History: _____ LMP: _____ Last PAP/HPV: _____

GPA: _____ Menarche: _____ Menopause: _____

Birth Control/Hormone Use: _____

Family History: _____

Breast Health History: _____

_____

II: Patient Concerns

_____

_____

_____

_____

_____

III: Breast Examination

Patient Name:_____

Visual Exam:

Skin: ☐ Normal/Benign ☐ Scar(s) ☐ Dimpling ☐ Other:_____

Nipples: ☐ Everted ☐ Inverted ☐ Retraction ☐ Discharge / Describe _____

Physical Exam:

	Left	Right
Lymph Nodes (Axillary/Clavicular)	+ ☐ - ☐	+ ☐ - ☐

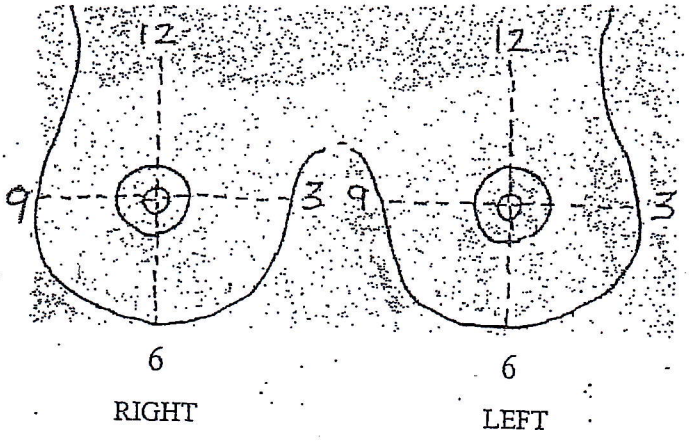

Diagram Documentation Codes

Scar	Nodularity
Mole *	Fibrocystic Area
Node o	Dimpling Δ
Mass ●	

Describe size, shape, mobility, clock location and any associated findings: _____

_____

_____

IV: Plan

[ ] Aspiration of Cyst

[ ] Fine Needle Aspiration

[ ] Mammogram

[ ] Sonogram (Please note findings on diagram)

[ ] Refer to Breast Clinic or other facility: _____

[ ] Biopsy / Spot Localization

[ ] Other: _____

_____

_____
Signature