Millennium Physicians
Breast Surgical Oncology

NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ Date of Birth:_____ Sex: Male Female

Social Security: _____ - ____ - _____ Insurance Carrier:_____ Insurance ID#:_____

Address: _____ Phone: (____)_____-_____ Cell/Wk: (____)_____-_____

Referring Physician: _____ Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other_____

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location

_____

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain **1 2 3 4 5 6 7 8 9 10**

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____
Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction_____
Any other allergies? Incl. Latex **YES** **NO** if yes please list_____

PHARMACY INFORMATION

For our patients convenience we have Millennium Pharmacy in our Kingwood and Woodlands locations, they also deliver to the office you are currently seeing your physician. However, you are can select any pharmacy of your choice. Please select your preferred pharmacy:

☐ MILLENNIUM PHARMACY WOODLANDS (281) 298-1129

☐ MILLENNIUM PHARMACY 2 KINGWOOD (281) 312-8585

☐ OTHER: _____ (___) ____-_____

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SOCIAL HISTORY

1) Do you or have you EVER used tobacco products? (circle one) **YES** or **NO**, if yes please complete 1A – 1B, in no skip to 2.

1A. Select All That Apply:

- ☐ Current smoker, every day
- ☐ Current smoker, some days
- ☐ Smoker, status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Former Smoker

1B. Select All That Apply:

- ☐ Cigarettes Amount:_____ per day
- ☐ Cigars Amount:_____ per day
- ☐ Smokeless Amount:_____ per day
- ☐ Pipes Amount:_____ per day

2) Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

3) Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

Mother:	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Father:	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Sister(s):	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Brother(s):	**Alive**	**Deceased**	Age:_____	Medical Condition:_____
Grandmother:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Grandfather:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Aunts:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Uncles:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____

PAST MEDICAL HISTORY

1) Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

- ☐ Pet Scan When_____ Where_____
- ☐ CT Scan When_____ Where_____
- ☐ Ultrasound When_____ Where_____
- ☐ Other (specify) When_____ Where_____

2) Have you been hospitalized in the last 6 months? **YES** **NO**
If YES, when_____ and reason for hospitalization _____

3) Please list any prior surgeries: _____

4) Please list any additional information about your medical history that the physician should know:
_____
_____

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WOMEN'S HEALTH HISTORY

Please complete this section for women only.

Date of Last Pap Smear: _____
Date of Last Mammogram:_____
Prior Breast Biopsies? Yes or No
If so, when and where: _____
Prior Breast surgery? Yes or No
If so, when and where: _____

Date of Last Period: _____
Age at first Period: _____

Bra size: _____
Are you currently pregnant? Yes or No
Number of pregnancies: _____
Number of children: _____
Age when first child was born: _____
Did you breast feed? Yes or No
If so, for how long: _____

Are you currently or ever taken contraceptive? Yes or No
If so, how long? _____

Post-Menopausal Women Only

Age at menopause:_____

Have you ever taken hormone replacement therapy? Yes or No
If yes, for how long:_____ Name of hormone replacement therapy: _____

REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

GENERAL
__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Excessive Weight Gain or Loss
__ Fever
__ Headache
__ Numbness

CARDIOVASCULAR
__ Chest Pain
__ High/Low Blood Pressure
__ Irregular/Rapid Heart Beat
__ Poor Circulation
__ Shortness Of Breath
__ Swelling In Ankles
__ Varicose Veins

SKIN
__ Any Chronic Rashes Or Eruptions
__ Change In Moles
__ Hives
__ Itching
__ Irregular Scars
__ Poor Healing Of Lesions or Wounds
__ Poor Healing Of Foot Lesions

EYE, EAR, NOSE, & THROAT
__ Bleeding Gums
__ Blurred Vision
__ Crossed Eyes
__ Difficulty Swallowing
__ Double Vision
__ Earache Or Ear Discharge
__ Hay Fever
__ Hoarseness
__ Loss of Hearing
__ Nosebleeds
__ Persistent Cough
__ Ringing In Ears
__ Sinus Problems
__ Vision – Flashes or Halos

GASTROINTESTINAL
__ Bloating
__ Black Or Tarry Stools
__ Bowel Changes
__ Change In Appetite
__ Constipation
__ Diarrhea
__ Excessive Thirst
__ Gas
__ Hemorrhoids
__ Indigestion/Heartburn
__ Nausea
__ Rectal Bleeding
__ Stomach Pain
__ Vomiting

HEMATOLOGIC
__ Anemia
__ Easy Bruising
__ Excessive Bleeding

RESPIRATORY
__ Chronic Cough
__ Coughing Up Blood
__ Wheezing Or Asthma

URINARY
__ Blood In Urine
__ Frequent Urination
__ Lack Of Bladder Control
__ Painful Urination

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NEUROLOGICAL

__ Double Vision/Vision Loss
__ Prior Stroke
__ Muscular Weakness/Tingling
__ Speech Difficulty
__ Transient Paralysis
__ Transient Neurologic Deficit

MUSCLE/BONE/JOINT

Pain, Weakness, Numbness In:

__ Arms
__ Back
__ Feet
__ Hands
__ Hips
__ Legs
__ Neck/Shoulders

MEN ONLY

__ Erection Difficulties
__ Lump In Testicles
__ Penis Discharge
__ Sore On Penis
__ Other Issue_____

Women ONLY

__ Abnormal Pap Smear
__ Bleeding Between Periods
__ Breast Lump
__ Extreme Menstrual Pain
__ Hot Flashes
__ Nipple Discharge
__ Painful Intercourse
__ Vaginal Discharge

__ Aids
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Breast Lump
__ Cancer
__ Cataracts
__ Chemical Dependency

__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Heart Disease
__ Hepatitis
__ Herpes
__ High Cholesterol

__ HIV Positive
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia

__ Polio
__ Prostate Problem
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers
__ Venereal Disease

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**

Millennium Physicians Association, PLLC

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Kingwood, Texas 77339
www.millenniumphysicians.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Continued next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- **For Treatment.** We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility, such as through a referral.
- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, compliance/risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates.** There are some services provided in our Facility through contracts with business associates. Examples include medical directors; outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers.** Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, etc.), therapists (e.g., Radiation Therapists, etc.), portable radiology units, clinical labs, hospice caregivers, pharmacies, financial counselor's,), etc.
- **Treatment Alternatives.** We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required by Law**. We will disclose health information about you when required to do so by federal, state or local law and obtain the proper authorizations to use and disclose information.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting.** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
  - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
    - Prevention or control of disease, injury or disability
    - Reporting births and deaths;
    - Reporting child abuse or neglect;
    - Reporting reactions to medications or problems with products;
    - Notifying people of recalls of products;
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
    - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
  - *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
  - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement.** We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;

- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution.** Should you be an inmate of a correctional institution; we may disclose to the institution or its agent's health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information and give you a copy of it.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the facility. This Notice of Privacy Practices applies to the following organizations: Millennium Physicians Associations, PLLC, Millennium Oncology, Millennium Radiation, Millennium PET/CT, Millennium Primary Care, Millennium Pulmonary Care, and any other service within Millennium Physicians.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a formal grievance/compliant against a nurse or physician, please contact the following agencies **(Nurse):** Texas Board of Nursing, 333 Guadalupe Street, Suite 3-460, Austin, Texas 78701, (512) 305-6838. **(Physician):** Texas Medical Board, PO Box 2018, Austin, Texas 78768-2018, (800) 201-0353. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Millennium Physicians Chief Compliance Officer Tomeshia S. Beckett - contact: (281) 359-9935 ext. 2128.