

**Porter Comprehensive Breast Care**  
**Colleen D. Murphy, M.D.**  
2555 South Downing, Suite 140, Denver, Colorado 80210  
Phone: 303-765-6380 Fax: 303-778-5268

**PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT**

- A picture I.D.
- Insurance Card(s) (if applicable)
- Any CDs/films relative to the breast area provided to you by an outside imaging center (if applicable)
- A complete list of current medications/supplements/herbals, etc. (both prescription and over-the-counter) along with their frequency and dosages

**\*\* The required forms referenced below are attached and/or included in this document for your completion/review prior to the appointment\*\***

- The completed "Patient Information Form"
- The completed "Patient Confidentiality Form"
- The completed "Medical/Health History "
- The signed "Acknowledgement of Receipt of Notice of Privacy Practices"
- The completed "Are you at Risk for a Fall Form"
- "Authorization to Obtain Patient Information" (Medical Records release form required for us to obtain any outside records.)

Our office is located in the Cancer Care Center on the Porter Hospital campus (between Harvard and Yale on South Downing). Should you have any questions or need specific directions to our office, please don't hesitate to contact us at 303-765-6380. We look forward to caring for you!

Sincerely,  
Porter Comprehensive Breast Care Team

## **Porter Comprehensive Breast Care Medical Insurance Educational Information**

There are many questions and misunderstandings regarding medical insurance coverage and terminologies used, in an ever-changing industry. There was a time where you'd pay your premium through your employer group, have a very minimum co-payment of \$5 or \$10, and the insurance company would pay everything else. Unfortunately, that is frequently not the case any longer. Below you will find information we hope will assist you in understanding your insurance coverage.

Our office will bill your insurance company for all the services provided to you (office visits, surgeries, procedures, etc.). Reimbursement from your insurance carrier to our office is based on our contractual agreement and our participation status. Your benefit plan will determine your financial responsibility for these services. Your responsibility may include a single or combination of the following:

- **Copayment:** A fixed amount that your insurance company requires you to pay to the physician at the time of service. A copayment may be due for each visit, dependent upon the type of service you require.
- **Deductible:** The amount you are responsible to pay for services rendered by our office before coverage begins, per calendar or benefit plan year. Some insurance carriers have individual deductibles, and/or family deductibles, which are required before they will make payment for eligible benefits.
- **Co-insurance:** In general, after your deductible has been satisfied in full, your insurance company will pay a percentage of the eligible amount of charges for service. You could be responsible for the remaining percentage of expenses beyond the deductible (up to a maximum). The percentage, as well as the maximum financial responsibility, is determined by your benefit plan structure with your insurance company.
- **Health Savings Account (HSA):** A tax-deductible account opened by an individual in combination with a large-deductible health insurance plan to assist in paying for medical expenses (frequently utilized for deductibles and co-insurance responsibilities).
- **Health Reimbursement Account (HRA):** A tax-exempt fund established by an employer for an employee. This HRA can be used to pay for medical expenses incurred, such as your copayments, co-insurance, deductible, or other eligible medical services/expenses.

The terms under which insurance policies establish eligibility and reimbursement vary widely among policies, and depend on your individual contract and benefit plan.

As the patient, it is your responsibility to know your insurance policy and benefits. We strongly encourage you to contact your insurance company to verify your plan benefits and limitations (copayment, deductibles, and/or co-insurance). Copayments, deductibles, co-insurance, and non-covered services are the member's responsibility and will be billed to the guarantor.

**Unless other payment arrangements have been pre-approved by our office, it is our office policy to collect your copayment at the time of service when you check in for your appointment. We will also collect a full or partial payment for your office visit, procedure(s), and/or surgery if your deductible and/or co-insurance has not yet been met. It is also important for you to be aware that hospital and physician services are billed separately, thus you may receive bills from each individual department/physician that provides services for you. Should you have any questions about this information, please let us know how we may assist you. We're here to care for you and are thankful you've chosen Centura.**

**Thank you!**

PATIENT INFORMATION FORM- PLEASE FILL OUT ALL INFORMATION

PATIENT'S PERSONAL INFORMATION

Name: last name first name initial
How do you wish to be addressed? Marital Status: Single Married Divorced Widowed
Social Security #: Date of Birth: Age: Sex: M F
Street Address: (Apt #) City: State: Zip:
Home Phone: Work Phone: Cell Phone:
Email Address:
Occupation: Employer Name:
Employment Status: Full Time Part Time Unemployed Student Retired

NEXT OF KIN

Name: Relationship to Patient:
Address: City: State: Zip:
Phone #: Other Phone #:

RELEASE OF HEALTH/BILLING CONSENT (Must be signed to be valid)

I give my permission for the following persons to speak with Dr. Colleen Murphy of Porter Comprehensive Breast Care regarding my Health/Billing Information:

1) Relationship: 2) Relationship:
Signature: Date:

PATIENT INSURANCE INFORMATION (Please present insurance cards to receptionist)

Primary Insurance Company's Name: ID #:
Group #: Co-pay Amount: Effective Date:
Subscriber's Name: SS #: DOB: Relationship to Patient:
Secondary Insurance Company: ID #:
Group #: Co-pay Amount: Effective Date:
Subscriber's Name: SS #: DOB: Relationship to Patient:

REFERRING PHYSICIAN AND YOUR PRIMARY CARE PHYSICIAN

Referred By: Phone #:
Primary Care Physician: Phone #:

EMERGENCY CONTACT (In Case of Emergency)

Name: Relationship:
Home Phone: Work Phone: Cell Phone:

I understand and acknowledge that my insurance coverage is a contract between my insurance company and myself and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Colleen Murphy, Dr. Seth Reiner, Porter Adventist Hospital and associates of Centura Health. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims.

If I am a member of a PPO or a HMO I am required to make my co-pay at the time of service and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current.

I authorize Dr. Nadine Mikhaeel, Dr. Thomas Kenney, Dr. Colleen Murphy, and Dr. Seth Reiner, Porter Adventist Hospital and associates of Centura Health to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to above physicians and associates. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or responsible party: Date: Witness:

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**PATIENT CONFIDENTIALITY**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Work Number: \_\_\_\_\_

Other Number: \_\_\_\_\_

**May we call you at your workplace?** YES  NO  N/A

**Please let us know with whom we can or cannot leave a message.**

NAME	YES	NO	N/A
Spouse _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
Home Voicemail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Voicemail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell Phone Voicemail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If a family member should contact our office, we will not to give out any information unless we have permission from you, the patient. Please let us know who we are able to give information to. Please include full names of individuals.

Spouse: \_\_\_\_\_

Parent: \_\_\_\_\_

Children: \_\_\_\_\_

Other: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



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**MEDICAL/HEALTH HISTORY**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PAST MEDICAL HISTORY: Please circle any of the following symptoms/conditions you have personally experienced any time in your life. There will be additional sections listed below for any symptoms/conditions you are currently experiencing, as well as, a family and social history. This information assists us in providing you with the best care possible.**

<b>General History:</b>	Insomnia (difficulty sleeping) Fibromyalgia	Chronic Pain	Other: _____ _____
<b>HEENT</b> (head, eye, ear, nose, throat)	Cataracts Glaucoma	Recurrent Ear Infections Recurrent Sinusitis	Other HEENT History: _____:
<b>Endocrine/Metabolic</b>	Diabetes Type 1 Diabetes Type 2 Hyperlipidemia (high cholesterol)	Graves Disease Hyperthyroidism (over-active thyroid) Hypothyroidism (under-active thyroid)	Other Endocrine History: _____ Other Metabolic History: _____
<b>Respiratory</b>	Allergies/Hay Fever Asthma	COPD (Chronic Obstructive Pulmonary Disease) Sleep Apnea	Other Respiratory History: _____
<b>Cardiac</b>	Angina (chest pain resulting from insufficient blood to the heart) Atrial Fibrillation Cardiac Arrhythmias (problem with either the rate or rhythm of the heartbeat)	Coronary Artery Disease (Congestive) Heart Failure Hypertension (high blood pressure)	Heart Valve Disease Myocardial Infarction (Heart Attack) Other Cardiac History: _____
<b>Vascular</b>	PE (Pulmonary Embolism-Blood Clot in the Lung)/DVT (Deep Vein Thrombosis) PAD (Peripheral Artery Disease) Aneurysm	CVA/Stroke TIA (Transient Ischemic Attack)	Peripheral Vascular Disease Other Vascular History: _____

<b>Gastrointestinal (GI)</b>	Colitis GERD (Gastroesophageal Reflux Disease) Irritable Bowel Syndrome	Liver Disease Pancreatitis	Peptic Ulcer Disease Other GI History: _____
<b>Genitourinary</b>	Chlamydia Gonorrhea Herpes Genitalis Human Papillomavirus	Kidney Disease Kidney Failure Kidney Stones Past UTI (Urinary Tract Infections)	Syphilis Urinary Incontinence Other GU History: _____
<b>Gynecologic (GYN)</b>	Abnormal Pap Smear Chronic Pelvic Pain Endometriosis PID (Pelvic Inflammatory Disease)	Polycystic Ovarian Syndrome Recurrent Vaginal Infections Infertility	Fibroids Fibrocystic Breast Disease Other GYN History: _____

**How old were you when you had your first period?** \_\_\_\_\_

**Date of last menstrual cycle?** \_\_\_\_\_

**Age at Menopause?** \_\_\_\_\_

<b>Pregnancy/Nursing History</b>	Have you ever been pregnant?	Yes	No
	If yes, number of:	Pregnancies: _____ Tern Deliveries: _____ Pre-Term Deliv.: _____ Living Children: _____ How old were you when your first child was born? _____ Did you breast feed? Yes      No If yes, for how long? _____	Miscarriages: _____ Terminations: _____ Ectopic: _____
	Have you ever used pills or hormone shots for birth control?	Yes Approx. Date(s): _____	No

	Have you ever taken fertility medicine or fertility treatments?	Yes Please describe type(s) and number of cycles: _____ _____	No
	Have you ever used hormone replacement therapy?	Yes Approx. Date(s): _____	No
<b>Musculoskeletal</b>	Arthritis Degenerative Disc Disease	Fracture(s) (location: _____ _____) Gout	Osteoporosis Other Musculoskeletal History: _____
<b>Autoimmune</b>	Raynauds Lupus	Rheumatoid Arthritis	Other: _____
<b>Hematologic</b>	Anemia Iron Deficiency Anemia	Anemia of Chronic Disease Thalassemia	Pernicious Anemia Other: _____
<b>Cancer</b>         <b>Female Cancer</b>	Blood Cancer Brain Cancer Breast Cancer Colorectal Cancer Endocrine Cancer Eye Cancer GI (Gastrointestinal) Cancer Cervical Cancer Ovarian Cancer	Genitourinary Cancer Kidney Cancer Leukemia Liver Cancer Lung Cancer Lymphoma Musculoskeletal Cancer Uterine Cancer	Neurologic Cancer Oral Cancer Skin Cancer Stomach Cancer Thyroid Cancer Other Cancer History: _____ _____
	Have you ever had radiation therapy to the neck or chest?	Yes Approx. Date(s): _____	No

<b>Infectious Disease</b>	AIDS Chickenpox Hepatitis A Hepatitis B Hepatitis C HIV Measles	MRSA Mumps Polio Positive PPD (Skin Test for Tuberculosis Exposure) Rheumatic Fever	Rubella Syphilis Tuberculosis Vanco-Resistant Enterococcc (Vanco Resistant Disease) Other Infectious Disease History: _____
<b>Skin</b>	Acne Eczema	Psoriasis	Other Diseases/Conditions: _____
<b>Neurologic</b>	Autism Dementia Developmental Delay Headaches	Migraines Multiple Sclerosis Parkinsons Disease Peripheral Neuropathy	Restless Leg Syndrome Seizures Other Neurological History: _____
<b>Psychiatric</b>	ADHD Anorexia Nervosa Anxiety	Bipolar Disorder Bulimia Depression	Schizophrenia Other Psychiatric History: _____
<b>Genetic</b>	Cystic Fibrosis	Down Syndrome	Other Genetic History: _____
	Do you have Ashkenazi Jewish Ancestry?	Yes	No
	Do you have Ancestors from San Luis Valley or who are New Mexican Latino?	Yes	No
<b>Events</b>	Anaphylaxix (Severe Whole Body Allergic Reaction) Gunshot Wound	MVA Blood Transfusions	Other Event History: _____
<b>Disabilities</b>	Hearing Deficit Vision Deficit	Hemiparesis Paraplegia	Quadriplegia Other Disabilities: _____

**PAST SURGICAL HISTORY**

I have never had surgery of any kind

<p><b>HEENT</b> (head, eye, ear, nose, throat)</p>	<p>Cataract Extraction Laryngectomy Tonsilectomy</p>	<p>Other Head Surgery: _____ Other Eye Surgery: _____ Other Ear Surgery: _____</p>	<p>Other Nasal Surgery: _____ Other Throat Surgery: _____</p>
<p><b>Endocrine</b></p>	<p>Parathyroidectomy (aka Parathyroid Gland Removal)</p>	<p>Thyroid Surgery</p>	<p>Other Endocrine Surgery: _____</p>
<p><b>Respiratory</b></p>	<p>Bronchoscopy (a procedure used to look inside the lungs' airways)</p>	<p>Lobectomy</p>	<p>Other Chest Surgery: _____</p>
<p><b>Cardiovascular</b></p>	<p>Angiogram Angioplasty CABG Surgery (Heart Bypass Surgery) Carotid Endarterectomy (Surgical Procedure Used to Prevent Stroke)</p>	<p>Coronary Stent Heart Transplant Pacemaker Valve Replacement</p>	<p>Vascular Stent Vascular Graft Other Cardiac Surgery: _____</p>
<p><b>Gastrointestinal (GI)</b></p>	<p>Appendectomy (Surgical Removal of the Appendix) LAP/Open Cholecystectomy (Surgical Removal of the Gallbladder) Colectomy (Surgical Removal of the Colon)</p>	<p>Hiatal Hernia Incisional Hernia (Protrusion of an Organ Through the Wall that Usually Contains it) Inguinal Hernia (Groin Hernia)</p>	<p>Ventral Hernia (Abdominal Hernia) Splenectomy (Surgical Removal of the Spleen) Other GI Surgery: _____</p>
<p><b>Genitourinary (GU)</b></p>	<p>Bladder Surgery Kidney Stone Extraction</p>	<p>Nephrectomy (Surgical Removal of Kidney) Renal Transplant</p>	<p>Other GU Surgery: _____</p>
<p><b>Gynecologic (GYN)</b></p>	<p>Cervical Conization/LEEP Cesarean Delivery</p>	<p>Hysterectomy (Surgical Removal of the Uterus) Date: _____ Reason: _____ Oophorectomy (Surgical</p>	<p>Tubal Ligation Other GYN Surgery: _____</p>

		Removal of the Ovaries) One      Both Date: _____	
<b>Musculoskeletal</b>	Amputation Open Reduction Internal Fixation (ORIF-Surgical Repair of Fractured Bone)	Joint Replacement Cervical Spine	Lumbar Spine Other Musculoskeletal Surgery: _____
<b>Skin</b>	Skin Cancer Removal	Other Skin Surgery: _____	
<b>Neurologic</b>	Craniotomy	Carpel Tunnel Release	Other Neurologic Surgery: _____
<b>Breast</b>	Breast Biopsy Breast Lesions	Lumpectomy Mastectomy	Other Breast Surgery: _____

If **yes**, to any of the above, please answer the following:

Year	Reason (Circle)				Side (Circle)	
	Lump	Cyst	Abnormal Mammogram	Cancer	Left	Right
	Lump	Cyst	Abnormal Mammogram	Cancer	Left	Right
	Lump	Cyst	Abnormal Mammogram	Cancer	Left	Right
	Lump	Cyst	Abnormal Mammogram	Cancer	Left	Right

**FAMILY MEDICAL HISTORY: To the best of your knowledge, please circle any of the following symptoms/conditions any blood-related relatives are currently experiencing or have experienced in the past.**

Family History is Unknown

Are you adopted: Yes No

<b>General History:</b>	Insomnia (difficulty sleeping) Fibromyalgia	Chronic Pain	Other: _____ _____
<b>HEENT</b> (head, eye, ear, nose, throat)	Vision Problems	Hearing Problems	Other HEENT History: _____: _____
<b>Endocrine/Metabolic</b>	Diabetes Lipid Disorders	Thyroid Disorders	Other Endocrine or Metabolic History: _____ _____
<b>Respiratory</b>	Asthma	COPD (Chronic Obstructive Pulmonary Disease)	Other Respiratory History: _____ _____
<b>Cardiovascular</b>	ASCVD (Arteriosclerotic Cardiovascular Disease) CHF (Congestive Heart Failure) PE (Pulmonary Embolism-Blood Clot in the Lung)/DVT (Deep Vein Thrombosis)	Early Cardiac Death Myocardial Infarction (Heart Attack) Hyperlipidemia (High Cholesterol)	Hypertension (high blood pressure) Other Cardiac History: _____ _____
<b>Gastrointestinal (GI)</b>	Familial Polyposis (Polyps)	Gluten Enteropathy (Gluten Sensitivity)	Other GI History: _____ _____
<b>Genitourinary</b>	Kidney Disease	Kidney Failure	Other GU History: _____ _____
<b>Gynecologic (GYN)</b>	Did your mother take DES (Diethylstilbestrol) when pregnant with you?  * From about 1940 to 1970, DES was given to pregnant women under the mistaken belief it would reduce the risk of pregnancy complications and losses.	Yes	No

	○ Unknown		
<b>Musculoskeletal</b>	Osteoarthritis Osteoporosis	Other Arthritis	Other Musculoskeletal History: _____
<b>Autoimmune</b>	Raynauds Lupus	Rheumatoid Arthritis	Other: _____
<b>Hematologic</b>	Hypercoagulable State (Abnormal Tendency Towards Blood Clotting) Recurrent VTE (Recurrent Venous Thromboembolism= Blood Clots)	Hemoglobinopathy (genetic disorder affecting the blood - one example is sickle cell disease)	Other: _____
<b>Cancer</b>	<p><b>Breast Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p><b>Colorectal Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p><b>Ovarian Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side</p>	<p><b>Prostate Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p><b>Uterine Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p>	<p><b>Lung Cancer</b></p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p><b>Other Cancer History:</b></p> <p>Type _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Type _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p> <p>Age at Diagnosis: _____</p> <p>Type _____</p> <p>Relative: _____</p> <p>Mother's or Father's Side (please circle one)</p>

	(please circle one) Age at Diagnosis: _____		Age at Diagnosis: _____
<b>Infectious Disease</b>	Hepatitis B Hepatitis C	HIV Tuberculosis	Other Infectious Disease History: _____
<b>Skin</b>	Psoriasis		Other Diseases/Conditions: _____
<b>Neurologic</b>	Migraines Parkinsons Disease CVA (Stroke)	Developmental Delay Multiple Sclerosis Seizures	Degenerative Neurological Condition (e.g. Alzheimers) Other Neurologic History: _____
<b>Psychiatric</b>	Depression Bipolar Disorder Suicide	Dementia Alcohol Abuse Substance Abuse	Schizophrenia Other Psychiatric History: _____
<b>Genetic Disorders</b>	Genetic Disorders	Other Genetic History: _____	

**SOCIAL HISTORY: This section pertains to you personally. How would you best describe your....**

<b>Marital Status</b>	Single Married	Divorced Widowed	Other: _____
<b>With Whom do you Live?</b>	Alone Children	Parent(s) Spouse/Partner	Other: _____
<b>Occupation (Former if Retired)</b>			

<b>Tobacco Use</b>	No Tobacco Use Cigarettes Pipe/Cigar	Chew Secondhand Exposure	Quit date(s): _____ _____ Other: _____
	Packs Smoked/Day: _____ Total Years Smoked: _____		
	<b>Counseling</b> Not Considered Quitting Considering Quitting Quit Date Established	Provider Counseling Support Medications	Support Program Other: _____
<b>Alcohol Use</b>	None In Recovery Occasional One Drink/Day	More Than One Drink/Day Binge Ever Tried to Cut Down Annoyed by Criticism	Feel Guilt About Drinking Need Eye-Opener Other: _____
<b>Drug Use</b>	Current Use	Remote Use	
<b>Drug Use Details</b>	Route Amphetamines Cocaine Designer/Club	Hallucinogens Heroin Inhalants Marijuana	Narcotics Opiates Sedatives Other: _____
<b>Additional History</b>	Number of Sisters: _____		Number Living: _____
	Number of Brothers: _____		Number Living: _____
	Is Your Mother Living	Yes Current Age: _____	No Age at Death: _____ Cause: _____
	Is Your Father Living	Yes Current Age: _____	No Age at Death: _____ Cause: _____
	Any additional history you would like us to be aware of?		

**CURRENT SYMPTOMS/CONDITIONS: Please circle any of the following symptoms/conditions you are currently experiencing or have experienced within the last two weeks.**

<b>Constitutional</b>	Appetite Change Excessive Sweating Fatigue	Fever Night Sweats Weight Gain	Weight Loss Other: _____
<b>Eyes</b>	Blurred Vision Corrective Lenses Diplopia (Double-Vision)	Eye Irritation Eye Pain Spots in Vision	Vision Loss Other: _____
<b>Ears, Nose, Mouth, Throat</b>	Ear Pain Hearing Loss Tinnitus (Ringing in the Ears) Vertigo (Dizziness) Facial Pain	Nasal Discharge Nasal Obstruction Nosebleeds Postnasal Drainage Bleeding Gums	Dental Pain Mouth Lesions (Sores) Hoarseness Sore Throat Other: _____
<b>Cardiovascular</b>	Chest Pain Decreased Exercise Tolerance Exertional Dyspnea (Shortness of Breath with Exertion) Orthopnea (Breathlessness When Lying Down)	Palpitations Syncope (unconsciousness) Claudication (Blood Clots)	Leg Ulcers Peripheral Edema (Swelling in the Arms and/or Legs) Other: _____
<b>Respiratory</b>	Cough Sputum Production Hemoptysis (Coughing Up Blood)	Shortness of Breath Pleuritic Pain (Sharp Chest Pain Made Worse with Deep Breathing/Coughing) Wheezing	Snoring Apnea (Low Oxygen with Sleep-CPAP) Other: _____
<b>Gastrointestinal</b>	Abdominal Pain Bloating Food Intolerance Nausea Vomiting	Dysphagia (Difficulty Swallowing) Reflux/Heartburn Change in Bowel Habits Constipation	Diarrhea Black Stools Bloody Stools Other: _____
<b>Genitourinary</b>	Change in Urinary Stream Dysuria (Painful or Difficult Urination) Hematuria (Blood in Urine)	Nocturia (Awaking from Sleep to Urinate) Change in Urinary Frequency Urinary Urgency	Dyspareunia (Painful Intercourse) Sexual Dysfunction Vaginal Discharge

	Incontinence	Dysmenorrhea (Painful Menstruation)	Other: _____
<b>Musculoskeletal</b>	Back Pain Joint Pain Joint Swelling	Limited Range of Motion Muscle Aches Muscle Weakness	Stiffness Other: _____
<b>Neurologic</b>	Abnormal Gait Focal Weakness (Specific Weakness as in Arm/Leg Weakness) Headache Incoordination	Memory Problems Numbness Seizures	Slurred Speech Tremors Other: _____
<b>Psychiatric</b>	Anxiety Decreased Concentration Irritability	Panic Attacks Sleep Disturbances	Sadness/Tearfulness Other: _____
<b>Endocrine</b>	Polydipsia (Excessive Thirst) Polyphagia (Excessive Appetite)	Polyuria (Excessive Urination)	Other: _____
<b>Hematologic/Lymphatic</b>	Bruising Bleeding Tendencies	Lymphadenopathy (Swelling/Enlargement of the Lymph Nodes) Recurrent Infections	Other: _____
<b>Allergic/Immunologic</b>	Eczema Seasonal Allergies	Urticaria (Hives/Rash)	Other: _____
	Do you have any allergies to medications, latex, or other?	Yes  What: _____ Reaction: _____  What: _____ Reaction: _____  What: _____ Reaction: _____	No

<b>Why are you here today?</b>	Current Symptoms:		
	How were they discovered?		
	When		
	Are you currently experiencing any pain related to the reason you are here today?	<p>Yes</p> <p>If yes, on a scale of 0 (No pain) to 10 (the worst pain imaginable), what would you rate it?</p> <p>_____</p>	No
	Are you currently experiencing any menopausal symptoms?	<p>Yes</p> <p>If yes, which?</p> <p>Hot Flashes</p> <p>Difficulty Sleeping</p> <p>Mood Swings</p> <p>Vaginal Dryness</p> <p>Thinning Hair</p> <p>Other: _____</p>	No
	Do you have Advance Directives?	Yes	<p>No</p> <p>If no, would you like information on them today?</p> <p>Yes      No</p>
<b>How did you hear about our practice?</b>	<input type="radio"/> Primary Care Physician _____ <input type="radio"/> OB/GYN or Other Specialist _____ <input type="radio"/> Family/Friend _____		<input type="radio"/> Website <input type="radio"/> Direct Mail Received at Home <input type="radio"/> Ad/Flyer on TV/in Newspaper <input type="radio"/> Support Group <input type="radio"/> Other: _____

<p><b>Which physicians would you like to receive information on your treatment in our office?</b></p>	<p>Name: _____</p> <p>Specialty: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Address:</p>
	<p>Name: _____</p> <p>Specialty: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Address:</p>
	<p>Name: _____</p> <p>Specialty: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Address:</p>

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

[ ] MD REVIEWED ENTIRE INTAKE FORM [ ] on date of visit  
**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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Optional Notice of Privacy Practice Acknowledgment Form

Individual Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I acknowledge that I received a copy of Porter Comprehensive Breast Care's Notice of Privacy Practices.

\_\_\_\_\_  
Individual's signature or initials

\_\_\_\_\_  
Personal representative of individual, if individual is unable to sign      Date

\_\_\_\_\_  
Witness signature

**Section below this line is for office use only. Thank you.**

\_\_\_\_\_

\_\_\_\_\_

Individual (or personal representative of the individual) did not sign the acknowledgment for the following reason:

(Check one of the reasons below)

- Individual refused
- Individual refused, stating that he/she has already signed an acknowledgement
- Individual unable to sign because of medical condition
- There was not a personal representative of the individual available to sign
- Other: (explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## ARE YOU AT RISK FOR A FALL?

Date: \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Patient \_\_\_\_\_ Caregiver \_\_\_\_\_ Other (please specify \_\_\_\_\_)

### PLEASE SELECT "YES" OR "NO" FOR EACH STATEMENT.

1. I need help to walk, get up from a chair, or lie down.

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Sometimes I do not know where I am or what is going on around me.

Yes \_\_\_\_\_ No \_\_\_\_\_

3. I have vision or hearing problems that affect my ability to walk.

Yes \_\_\_\_\_ No \_\_\_\_\_

4. I take medications that may make me unsteady/dizzy.

Yes \_\_\_\_\_ No \_\_\_\_\_

5. I have fallen within the last three months.

Yes \_\_\_\_\_ No \_\_\_\_\_

6. Sometimes I cannot control my urine or bowels.

Yes \_\_\_\_\_ No \_\_\_\_\_

7. I use a device, such as a cane or walker, to assist me with walking.

Yes \_\_\_\_\_ No \_\_\_\_\_

If you have answered "Yes" to any of the statements listed above, you are at risk for falling. An associate will work with you to take precautionary measures.

Patient Sticker

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