

**R.V. RAO, M.D., M.S. (Surg) F.A.C.S., F.I.C.S.**

Diplomate American Board of Surgery  
General Surgery and Vascular Surgery

**PATIENT REGISTRATION**

DATE

NAME	MARITAL STATUS <b>S   M   W   D   SEP</b>	DATE OF BIRTH	
STREET ADDRESS		CITY STATE, ZIP	
PHONE (HOME)	(WORK)	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION
S S #	DRIVER'S LICENCE #	REFERRED BY	

**INSURANCE & BILLING INFORMATION**

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE #

**PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I D.#	GROUP #
		BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I D #	GROUP #
		BENEFIT CODE
MEDICARE #	MEDICAID I D #	
OTHER COVERAGE		

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. RAO, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. RAO, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**MEDICARE - MEDICAID**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf

*A photocopy of these assignments shall be valid as the original.*

PATIENT (please print)	DATE
PARENT / GUARDIAN (please print)	SIGNATURE

# INFORMAT FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination  
It will help your physician to know not only about your health but also about your family and relatives

TODAY'S DATE

NAME		ADDRESS		
TELEPHONE NUMBER	DATE OF BIRTH	AGE	PLACE OF BIRTH	RACE OR NATIONALITY OF PARENTS
RELIGION		EDUCATION (Highest level attained)	OCCUPATION ▶	HOW LONG
PRESENT MARRIAGE (Year married)		PREVIOUS MARRIAGE (Year married and duration)		

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE ▶	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED ▶	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS ▶	NO ALIVE	HEALTH		NO DECEASED	CAUSE OF DEATH	
SISTERS ▶	NO ALIVE	HEALTH		NO DECEASED	CAUSE OF DEATH	
CHILDREN ▶	NO ALIVE	AGES & HEALTH		NO DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Tuberculosis  
  Heart disease  
  Stroke  
  High blood pressure  
  Nervous illness  
  Allergy  
  Other  
  Diabetes  
  Cancer  
  Bleeding tendency  
  Kidney disease

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD

Cancer  
  Asthma  
  Jaundice  
  Gonorrhea  
  Bleeding tendencies  
  Tuberculosis  
  Pneumonia  
  Kidney disease  
  Diabetes  
  Glaucoma  
  Heart trouble  
  Syphilis  
  Vein trouble  
  Rheumatic fever  
  Nervous disorder  
  Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

.....

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC. ?

No    Yes ▶ LIST

.....

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

NO    Yes ▶ LIST

.....

DO YOU USE TOBACCO NOW?	IN THE PAST?	TYPE AND DAILY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		
DO YOU USE ALCOHOLIC BEVERAGES?		TYPE	WEEKLY AMOUNT
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			
DO YOU DRINK COFFEE?		WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

Smallpox  
  Tetanus  
  Typhoid  
  Polio  
  Influenza  
  Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

.....

DENTAL (List any problems you have now)

.....

MEDICATIONS (Name or otherwise identify medicines now or recently used)

.....

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular		
HAVE YOU TAKEN CORTISONE-TYPE DRUGS?		ORAL CONTRACEPTIVES?	HAVE YOU RECEIVED A BLOOD TRANSFUSION?
<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes ▶ DATE
DRESSED WEIGHT		HOW LONG HAVE YOU BEEN AT THIS WEIGHT?	

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

.....

WHAT IS YOUR MAIN SYMPTOM?

.....

REVIEWED BY (Physician)	DATE
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**Breast Disorders Medical Clinic**  
**DR. R.V. RAO, M.D.**  
**Breast Questionnaire**

What is your main problem? \_\_\_\_\_

	<u>Right Breast</u>		<u>Left Breast</u>	
	Yes	No	Yes	No
<b>A. Lump in the Breast:</b>				
1. How long have you noticed the lump? _____ Which one?	---	---	---	---
2. Do you get frequent lumps/cysts in the breast?	---	---	---	---
3. Is the lump painful?	---	---	---	---
4. Does the lump increase in size?	---	---	---	---
<b>B. Pain in the Breast Region:</b>				
1. Is the pain all over the breast?	---	---	---	---
2. Is the pain over certain areas?	---	---	---	---
3. Is the pain all the time?	---	---	---	---
4. Does the pain increase during periods?	---	---	---	---
5. Does the pain increase with intake of hormones?	---	---	---	---
6. Does the pain increase or decrease with diet changes?	---	---	---	---
<b>C. Discharge from Nipple:</b>				
1. Have you noticed any nipple retraction?	---	---	---	---
2. Have you noticed any crusting on the nipple?	---	---	---	---
3. Have you had any nipple itching?	---	---	---	---
4. Have you noticed any nipple discharge?	---	---	---	---
If yes, circle one:				
<i>Bloody,</i>	<i>Serous,</i>	<i>Greenish,</i>		
<i>Milky,</i>	<i>Pink,</i>	<i>Sticky</i>		
<i>Multicolored</i>				
5. Is the discharge constant or intermittent?	---	---	---	---
6. Is the discharge related to your periods?	---	---	---	---
<b>D. Screening Information:</b>				
1. Have you had a mammogram within the last 1-2 years? _____				
2. Where did you have the mammogram done? _____				
3. Have you had a breast examination done by your physician?	circle: Yes	No		
4. Do you do monthly self breast examinations?	circle: Yes	No		

**Breast Disorders Medical Clinic  
DR. R.V. RAO, M.D.**

**Breast Questionnaire History**

	<u>Right Breast</u>		<u>Left Breast</u>	
	Yes	No	Yes	No
<b>A. Previous History of Breast Cysts:</b>				
1. Do you have a history of breast cysts?	---	---	---	---
2. Have you had a breast biopsy done previously?	---	---	---	---
3. Have you had a previous breast surgery?	---	---	---	---
4. Have had any breast conditions treated?	---	---	---	---
<b>B. Menstrual &amp; Gynecological:</b>				
1. Are you pregnant?	Yes	___	No	___
2. Do you have irregular periods?	Yes	___	No	___
3. What age did you start menstruating?	Yes	___	No	___
<b>C. Obstetrical History:</b>				
1. How many pregnancies have you had?	-----			
2. How many children do you have?	-----			
3. What is the age of your youngest child?	-----			
4. Did you breast feed your children?	Yes	___	No	___
<b>D. Family History:</b>				
1. Does anyone in your family have or had the following: (circle one)				
a) Breast Cancer	No	___	Yes	___
b) Breast Cysts	No	___	Yes	___
c) Breast Surgery	No	___	Yes	___
	Grandmother, Mother, Aunt, Daughter			
	Grandmother, Mother, Aunt, Daughter			
	Grandmother, Mother, Aunt, Daughter			
<b>E. Medication History:</b>				
1. Are you taking birth control pills?	Yes	___	No	___
2. Are you taking hormones?	Yes	___	No	___
3. Are you taking tranquilizer/ anti-depressant medication?	Yes	___	No	___
<b>F. Diet History:</b>				
Do you regularly drink:				
1. Coffee?	Yes	___	No	___
	Daily amount? _____			
2. Tea?	Yes	___	No	___
	Daily amount? _____			
3. Soft Drinks (containing caffeine)?	Yes	___	No	___
	Daily amount? _____			