Date: ____________________

Dear: __________________________________

Welcome to the USF Breast Health Program at the *Life Hope Medical Office Building*. Our goal is to meet the needs of breast patients and their families by providing a multidisciplinary team approach to your care.

Attached you will find your appointment instructions. The USF Breast Health Program is located at 3000 Medical Park Drive, Suite 160 Tampa, FL 33613. Parking is available on both sides of the building for your convenience. Once you enter the building, proceed to Suite #160 and stop at the USF registration desk. The registration process will take about 30 minutes so please allow time for this in planning your visit to the USF Breast Health Program.

Information about your medical history is necessary for us to provide you with quality care. Please take a few minutes to fill out the health history questionnaire included in the packet. Please bring the questionnaire with you when you come in for your appointment (do not mail it). The information is confidential and will not be shared with anyone without your permission. If you need help completing the questionnaire, please tell the registration counselor and they will assist you.

Evaluating your outside medical records is important for us to understand the reason for your appointment and your individual needs. You will need to contact your outside physician(s) and make arrangements to have your records sent to the USF Breast Health Program. A current mammogram is required so if you have not had one in the last year, you will need to have one prior to seeing a physician at the USF Breast Health Program. This may be done at the USF Breast Health Program, but you must get a prescription for a mammogram from your primary care physician. Old mammogram films from other facilities are necessary to compare with new mammogram films. You will need to bring these films with you when you come for your appointment at the USF Breast Health Program.

A USF Breast Health Program Radiologist will interpret all of your radiology films. Original films are necessary; no copied films can be reviewed by USF Breast Health Program Radiologists. A complete set of films should include at least 2 years of screening mammograms and any recent (less than 1 year old) screening mammograms showing any abnormalities. In addition you should include any subsequent diagnostic mammograms and/or ultrasounds. Films and written reports from any surgical biopsies, such as needle localization, stereotactic cores or ABBI, are also required.

After the USF Breast Health Program Radiologist reviews your films, they will be returned to you. If additional exams are needed you may hear from the clinic coordinator to schedule any additional exams that may be necessary. We will do our best to schedule the studies as conveniently as possible to avoid any delays in your appointment with the USF Breast Health Program.

The review of your pathology is also an important step in your care at the USF Breast Health Program. Please contact the facility where you had the biopsy and ask for the glass slides and any written reports. Please be sure to ask them to include reports of hormone receptors and any additional stains. Please have your pathology slides sent to the following address:

University of South Florida
Department of Pathology and Cell Biology
Attn: Consult Division
12901 Bruce B. Downs Blvd
MDC 11
Tampa, FL 33613

In keeping with the mission of the USF Breast Health Program, which is to *"contribute to complete breast health care",* one of your options may be to participate in one or more research studies offered at USF Health. Through research, patients can participate in the development of new drugs, tests, and procedures. Participation in research is completely voluntary and if you choose not to participate, you will receive the same quality of care USF Health provides to all patients.

We would also like to invite you to visit our web site at: www.usfbreasthealth.org. Here you will find information about the USF Breast Health Program, including appointments, contacts, directions, educational materials, research, news and events and more. We also provide a secure Patient Portal that will allow you to interact with the Breast Program. This will include a Personal Data Manager, which will allow you to view and edit some of your personal data, such as address, clinical history, etc. It also includes a new Community Forum where you can post questions and view and respond to questions and answers from other patients and staff. It is designed to open a dialog to discuss issues in breast health. The Patient Portal requires you to register with your email address, by contacting our System Administrator at jking@health.usf.edu. Please note that your email address and other contact information will only be used by our staff for your breast health care and will never be released to any outside entities.

The New Patient Appointment Center will assist you with all these details. Please don't hesitate to call with any questions or comments. We are here to help you make your visit to the USF Breast Health Program a pleasant and efficient process.

Contact Information:

Clinical Care Coordinator:	Trudy Leopold-Sanford
New Patient Appointment:	813-793-4272

The USF Breast Health Program is located at:

3000 Medical Park Drive
Suite #160
Tampa, FL 33613

Sincerely,

Trudy Leopold-Sanford

USF HEALTH BREAST PROGRAM

Life Hope Medical Office Building
3000 Medical Park Drive
Suite #160 Registration
Tampa, FL 33613

From I-275

- Take Fletcher Ave. Exit 52 and proceed east
- Continue on Fletcher Ave 3 miles to Bruce B. Downs Blvd.
- Make a left onto Bruce B. Downs Blvd.
- And then right onto Medical Park Drive.
- The Breast Care Center is located on the left hand side
- Across from the UCH parking Garage.

From I-75

- Take Fletcher Ave Exit 266 and proceed west
- Continue on Fletcher Ave. for approximately 5 miles
- Make a right onto Bruce B. Downs Blvd.
- And then right onto Medical Park Drive.
- The Breast Care Center is located on the left hand side
- Across from the UCH parking Garage.

From I-4

- Take I-75 Exit 9 Northbound (towards Ocala)
- Continue on Fletcher Ave. for approximately 5 miles
- Make a right onto Bruce B Downs
- And then right onto Medical Park Drive.
- The Breast Care Center is located on the left hand side
- Across from the UCH parking Garage.

Breast Health Program
Life Hope Medical Office Building

New Patient Appointment Information

Patient Name: ____
USF Physician and Clinic: ____
Registration Appointment Date and Time: _______________________________________
Clinic Appointment Date and Time: ____

PLEASE BRING THE FOLLOWING INFORMATION WITH YOU TO YOUR FIRST VISIT

Insurance:

- All health insurance cards.
- Written insurance authorization for visit (required if you are insured under a managed care plan such as a PPO or HMO). PLEASE NOTE: if authorization is not presented, it may be necessary for you to pay in full for all procedures and visits before being seen.

Medical Records:

- Please bring all actual medications, in their containers, that you are currently taking (if any).
- Bring your completed health questionnaire (enclosed with this packet).
- A copy of all medical records which pertain to your condition. Realize that you may need to request these from several sources, such as your primary care physician, specialists, clinics and hospitals. We have enclosed information release forms that you can give these sources allowing them to send us the records. NOTE: if you desire a copy for your personal records, please make them before you visit as all paper records supplied to us become part of your permanent record, and the clinic do not have the facility to copy them.
- ACTUAL glass slides from your biopsy, with the pathology report. These are usually stored at the lab or hospital where you had the biopsy. Ask the surgeon or physician who performed the biopsy to assist you with locating them and having them sent to our clinic.
  ACTUAL films, for example, X ray films, mammogram films, ultrasound films, CT films, MRI films, bone scan films, arteriogram, or any other films related to your diagnosis. PLEASE INSIST that the actual ORIGINAL Films are given to you to bring to your appointment. Copies of films are usually of poor quality and cannot be properly interpreted. USF Health will return these films to you so you may return them to the supplier.

  All the above items are REQUIRED for us to provide you with proper diagnosis and treatment. Providing these will enable you to receive the full benefit of your first visit to the USF Breast Health Program. Please refer to your notes from your scheduling conversation with the Intake Specialist who scheduled you, or call the New Patient Appointment Center at: **813-793-4272.**

General Information

Initial visits can take from 2-4 hours. In addition to your physician, you may be seen by several other people during your visit, such as a Radiation Oncologist, Nurses, Fellows, etc. It is important for you to arrive early for your registration appointment. A registration counselor will make copies of your insurance cards, obtain signatures, and verify your information. Feel free to contact the New Patient Appointment Center with any questions or concerns at 813-793-4272.

Please do not staple

Please do not staple

USF Health Breast Clinic
Patient Survey

Mancer Center
at the
University of South Florida

Please fill out the following forms and answer all questions as completely as possible. If you have problems with any of the questions, please ask your nurse to assist you when you come in for your clinic visit.

The forms will be read by a computer so it is important to follow the examples given below.

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

0	1	2	3	4	5	6	7	8	9

Shade circles like this:

Not like this:

When you have completed the forms bring them with you the day you come to the Breast Clinic. Make sure to give the forms to the registration personnel. The forms will be sent to the nurse in charge of your clinic and the nurse will review the forms with you to answer any questions you may have. Do not hesitate to ask if you are not sure of how to answer any of the questions.

Comprehensive Breast Clinic
Moffitt Cancer Center
12902 Magnolia Drive
Tampa, FL 33612

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COMPREHENSIVE BREAST CLINIC
Patient Demographics

For Office Use Only

Patient ID Number: U S F - ___________

Date of visit: ___ / ___ / ______

SSN: ___ - __ - ____

Patient Information:

Last Name:

First Name: Initial:

Address:

Address (cont.) :

City:

State: Zip Code:

Phone: ___ - ___ - ____

Date of Birth: ___ / ___ / ______

Sex: ○ Female ○ Male

Email Address:

What is your natural origin or ancestry? (choose all that apply)

- ○ Great Britian
- ○ Ireland
- ○ Germany
- ○ Eastern Europe (Poland, Russia, Hungary, Czech., etc.)
- ○ Scandinavia (Norway, Sweden, Denmark, Findland)
- ○ Spain, Portugal
- ○ France
- ○ Italy
- ○ Greece
- ○ Canada
- ○ Mexico
- ○ Central America
- ○ South America
- ○ Puerto Rico
- ○ American Indian
- ○ Middle East
- ○ India, Pakistan
- ○ China
- ○ Japan
- ○ Africa
- ○ Caribbean Islands (Jamaca, etc.)
- ○ Other European countries
- ○ Other Asian or Pacific Islands
- ○ Don't Know
- ○ Other

If "Other", please specify:

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COMPREHENSIVE BREAST CLINIC
Patient Demographics

For Office Use Only

Patient ID Number: U S F - ______

Physician: ______

What is your ethnic or racial background? (choose all that apply)

- ○ White, non-Hispanic
- ○ White, Hispanic
- ○ Black, non-Hispanic
- ○ Black, Hispanic
- ○ Chinese
- ○ Japanese
- ○ Filipino
- ○ Native American, Eskimo or Aleutian
- ○ Hawaiian
- ○ Korean
- ○ Vietnamese
- ○ Ashkenazi Jewish (European origin)
- ○ Don't know
- ○ Other

If "Other", please specify: ______

What is your current marital status? (choose only one response)

- ○ Married
- ○ Divorced
- ○ Single
- ○ Other
- ○ Widowed

What is your current educational status? (choose only one response)

- ○ Some grade school
- ○ Some high school
- ○ High school graduate
- ○ Vocational/Technical beyond high school
- ○ Some college or associates degree
- ○ College
- ○ Graduate or Professional School
- ○ Other

What is your current employment status? (choose only one response)

- ○ Employed >= 32 hrs/wk
- ○ Employed < 32 hrs/wk
- ○ Full time student
- ○ Part time student
- ○ Homemaker
- ○ On medical leave
- ○ Disabled
- ○ Unemployed
- ○ Retired
- ○ Employed <32 hrs/wk & part time student
- ○ Other

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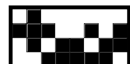

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number: U S F - ____________

Date of Visit: __ __ / __ __ / __ __ __ __

1. History of Present Medical Problem

SSN: ___ - __ - ____

Please note: If you have any additional information about your health that will not fit on this form, please write out the information on a seperate sheet of paper. Please be as complete as possible.

For what reason(s) are you visiting the clinic? (Check all that apply)

Routine breast exam:	○ Yes	○ No			
Palpable (can be felt) mass:	○ Yes	○ No			
Suspicion of breast cancer:	○ Yes	○ No			
Abnormal mammogram:	○ None	○ Right	○ Left	○ Both	
Followup to discuss treatment of breast cancer:	○ None	○ Right	○ Left	○ Both	
Followup after treatment of breast cancer:	○ None	○ Right	○ Left	○ Both	
Followup for fibrocystic changes:	○ None	○ Right	○ Left	○ Both	
New diagnosis of breast cancer:	○ None	○ Right	○ Left	○ Both	
If known, what type of cancer:	○ DCIS	○ LCIS	○ Invasive ductal	○ Invasive lobular	○ Other

What breast symptoms have you had?

New breast mass:	○ None	○ Right	○ Left	○ Both
If palpable breast mass, how large is it: __ __ . __ __	○ mm	○ cm	○ in	
Enlarging breast mass:	○ None	○ Right	○ Left	○ Both
New breast pain:	○ None	○ Right	○ Left	○ Both
Chronic breast pain:	○ None	○ Right	○ Left	○ Both

If you have breast pain, please describe the severity:

No pain	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	Worst pain ever

Premenstrual breast pain:	○ None	○ Right	○ Left	○ Both
Nipple discharge:	○ None	○ Right	○ Left	○ Both
If Yes, how often did you have nipple discharge:	○ Rarely	○ Daily	○ Continuous	
Nipple inversion:	○ None	○ Right	○ Left	○ Both
Erythematous (red) breast:	○ None	○ Right	○ Left	○ Both

How long have you noticed or suspected you may have had a breast problem? __ __ __ . __ ○ Days ○ Weeks ○ Months ○ Years

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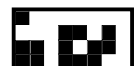


Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

2. Past Medical History

(Please answer **ALL** the following questions related to your health.)

Question	Answer
Have you ever had a heart attack?	○ No ○ Yes
Have you ever been treated for heart failure? (You may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping.)	○ No ○ Yes
Have you ever had an operation to unclog or bypass the arteries in your arms or legs?	○ No ○ Yes
Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain or transient ischemic attack (TIA)?	○ No ○ Yes
If Yes, do you have difficulty moving an arm or a leg as a result of a stroke or a cerebrovascular accident?	○ No ○ Yes
Do you have asthma, emphysema, chronic bronchitis or chronic obstructive lung disease?	○ No ○ Yes
If Yes, do you take medication for your condition (either on a regular basis or just for flare-ups)?	○ No ○ Yes
Do you have stomach ulcers or peptic ulcer disease?	○ No ○ Yes
If Yes, was this condition diagnosed by endoscopy (where a doctor looks into your stomach through a scope), or an upper GI or barium swallow study (where you swallow chalky dye and then x-rays are taken)?	○ No ○ Yes
Do you have diabetes or high blood sugar?	○ No ○ Yes
If Yes, please answer the following questions:	
Is it treated by monitoring your diet?	○ No ○ Yes
Is it treated by medications taken by mouth?	○ No ○ Yes
Is it treated by insulin injections?	○ No ○ Yes
Has your diabetes caused problems with your kidneys or problems with your eyes treated by an ophthalmologist?	○ No ○ Yes
Have you ever had problems with your kidneys?	○ No ○ Yes
If Yes, please answer the following questions:	
Have you had poor kidney function with blood tests showing high creatinine levels?	○ No ○ Yes
Have you used hemodialysis or peritoneal dialysis?	○ No ○ Yes
Have you received a kidney transplant?	○ No ○ Yes
Do you have rheumatoid arthritis?	○ No ○ Yes
If Yes, do you take medications for your arthritis regularly?	○ No ○ Yes
Do you have lupus (systemic lupus erythrematosus) or polymyalgia rheumatica?	○ No ○ Yes
Do you have Alzheimer's Disease or another form of dementia?	○ No ○ Yes
Do you have cirrhosis or severe liver disease?	○ No ○ Yes
Do you have leukemia or polycythemia vera?	○ No ○ Yes
Do you have lymphoma?	○ No ○ Yes
Do you have AIDS (HIV)? This question is optional.	○ No ○ Yes
Do you have any other cancer (other than breast cancer, skin cancer leukemia or lymphoma)?	○ No ○ Yes
If Yes, has the cancer spread or metastasized to other parts of your body?	○ No ○ Yes

Do you have any other medical problems?

If "Yes", please describe the problem(s) here:

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

2. Past Medical History (cont.)

Past Episode of Breast Cancer: ○ Yes ○ No

If "Yes", please enter the details of the last two (2) episodes here:

1. Type of breast cancer:
   - ○ Lobular carcinoma in-situ (LCIS)
   - ○ Invasive lobular
   - ○ Ductal carcinoma in-situ (DCIS)
   - ○ Invasive ductal
   - ○ Not specified
   - ○ Unknown
   - ○ Other

   If "Other", please describe

   Date of diagnosis (mm/dd/yyyy)

   [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

   Side

   ○ Left ○ Right ○ Both ○ Unknown

   Treatment

   ○ Chemotherapy ○ Radiation therapy
   ○ Hormone therapy ○ Surgery

2. Type of breast cancer:
   - ○ Lobular carcinoma in-situ (LCIS)
   - ○ Invasive lobular
   - ○ Ductal carcinoma in-situ (DCIS)
   - ○ Invasive ductal
   - ○ Not specified
   - ○ Unknown
   - ○ Other

   If "Other", please describe

   Date of diagnosis (mm/dd/yyyy)

   [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

   Side

   ○ Left ○ Right ○ Both ○ Unknown

   Treatment

   ○ Chemotherapy ○ Radiation therapy
   ○ Hormone therapy ○ Surgery

Personal History of Cancers Other than Breast Cancer: ○ Yes ○ No ○ Unknown

If "Yes", please enter the details here

1.

   Year of diagnosis

   [ ][ ][ ][ ]

   Treatment:

   ○ Chemotherapy ○ Radiation ○ None
   ○ Hormonal therapy ○ Surgery ○ Other

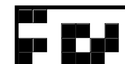
2.

   Year of diagnosis

   [ ][ ][ ][ ]

   Treatment:

   ○ Chemotherapy ○ Radiation ○ None
   ○ Hormonal therapy ○ Surgery ○ Other



Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

2. Past Medical History (cont.)

Which option below best describes your current level of physical activity WITHIN THE PAST WEEK? Please choose only one response.

- ○ Fully active, able to carry on all usual activities without restrictions.
- ○ Restricted in physically strenuous activity, but can walk and is able to carry out light housework.
- ○ Can walk and take care of yourself, but unable to carry out any work activities. Up more than half a day.
- ○ Need some help taking care of yourself, spend more than half a day in bed or a chair.
- ○ Cannot take care of yourself at all, and spend all of time in bed or a chair.

Do you perform Breast self exams: ○ No ○ Weekly ○ Monthly ○ Occasionally

3. Past Surgical History

History of Breast Surgery: ○ Yes ○ No ○ Unknown

If "Yes", please enter your last 2 breast surgeries

1. Date of surgery (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

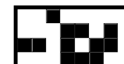
Age at time of surgery: __ __

Type of surgery:	Side:	Tumor type:	Treatment:
○ Excisional biopsy	○ Left	○ Benign	○ Chemotherapy
○ Core biopsy	○ Right	○ Malignant	○ Hormone therapy
○ Lumpectomy	○ Both	○ No residual tumor	○ Radiation therapy
○ Mastectomy		○ Atypical	
○ Implant		○ Unknown	
○ Implant removal			
○ Reduction			

2. Date of surgery (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Age at time of surgery: __ __

Type of surgery:	Side:	Tumor type:	Treatment:
○ Excisional biopsy	○ Left	○ Benign	○ Chemotherapy
○ Core biopsy	○ Right	○ Malignant	○ Hormone therapy
○ Lumpectomy	○ Both	○ No residual tumor	○ Radiation therapy
○ Mastectomy		○ Atypical	
○ Implant		○ Unknown	
○ Implant removal			
○ Reduction			



Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

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3. Past Surgical History (cont.)

History of Other Surgeries: ○ Yes ○ No ○ Unknown

If "Yes", please enter your last three (4) surgeries, starting with the most recent. Please include other surgeries for other cancers.

	Date (mm/dd/yyyy)	Type of surgery
1.	__ __ / __ __ / __ __ __ __	
2.	__ __ / __ __ / __ __ __ __	
3.	__ __ / __ __ / __ __ __ __	
4.	__ __ / __ __ / __ __ __ __	

Hysterectomy (Removal of the uterus)**:** ○ Yes ○ No ○ Unknown

Date of hysterectomy (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Reason for hysterectomy: ○ Excessive bleeding ○ Cancer ○ Unknown ○ Uterine fibroid ○ Endometriosis ○ Other

If "Other", please specify:

Oophorectomy (Removal of an ovary): ○ Yes ○ No ○ Unknown

Date of oophorectomy (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Side of oophorectomy: ○ Left ○ Right ○ Bilateral ○ Unknown

Reason for oophorectomy: ○ During hysterectomy ○ Benign ovarian mass ○ Unknown ○ Ovarian cancer ○ Endometrial cancer ○ Ovarian cyst ○ Other

If "Other", please specify:

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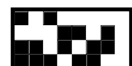

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

4. Diagnostic Studies

Mammograms

Date of most recent mammogram (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Age at most recent mammogram (years): ☐☐

Result of most recent mammogram: ○ Normal ○ Abnormal ○ Unknown

Ultrasound

Date of most recent ultrasound (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Age at most recent ultrasound (years): ☐☐

Result of most recent ultrasound: ○ Normal ○ Abnormal ○ Unknown

5. Current Medications

Please list any medications you are now taking, including *vitamins* and *non-prescription* drugs. If there are more than 12, please attach a seperate sheet listing the other medications.

	Medication	Dose (include units)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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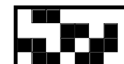

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-									

6. Allergies to Medications or Treatments ○ Yes ○ None ○ Unknown

Please list all known medications or treatments you are allergic to and the reaction you have. Also, include any reactions you have had to X-Ray studies. If there are more than 5, please attach a separate sheet listing the other allergies.

	Medication and/or Treatments	Type of reaction (choose all that apply)
1.		○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
2.		○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
3.		○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
4.		○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
5.		○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed

7. Social History

Marital status: ○ Married ○ Single ○ Widowed ○ Divorced

Where were you born?

Where were you raised?

How many years have you been in Florida?

Current/Former occupation:

Have you ever been a smoker? ○ Yes ○ No

If yes, please answer the following:

Total years as a smoker:

Number of cigarettes per week:
(1 pack = 20 cigarettes)

Packs per day: .

Date started: / /

If you have quit please give the date stopped: / /

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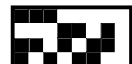

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

7. Social History (Cont.)

Do you drink alcoholic beverages? ○ Yes ○ No

Note: If you drink only occasionally, please answer "0".

How many beers do you drink per week:	○ 0	○ 1 - 2	○ 3 - 4	○ Greater than 5
How many glasses of wine do you drink per week:	○ 0	○ 1 - 2	○ 3 - 4	○ Greater than 5
How much hard liquor do you drink per week:	○ 0	○ 1 - 2	○ 3 - 4	○ Greater than 5

Do you drink caffeinated beverages? ○ Yes ○ No

How many cups of coffee or tea per day? ☐☐

How many soft drinks (soda) per day? ☐☐

What type? ☐

Exercise:

What type(s) of exercise do you engage in? ☐

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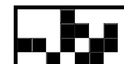

Comprehensive Breast Clinic Clinical History

For Office Use Only

Patient ID Number

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8. Reproductive History (female only)

Menstrual History

Age at first menstrual cycle? [ ][ ] (years)

Present menstrual status?
- ○ Premenopausal ○ Removal of ovaries ○ Unknown
- ○ Postmenopausal ○ Perimenopausal

If you have ceased menstrual activity for more then 12 months, what was the age when this occured? [ ][ ] (years)

Date of last period [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Have you had a menstrual period in the last 6 months?
- ○ No
- ○ Yes, natural menstrual periods
- ○ Yes, menstrual periods on birth control pills
- ○ Yes, menstrual periods on hormone replacement therapy

If you have NOT had a menstrual period in the last 6 months, why have your periods stopped?
- ○ Pregnancy and/or breast feeding
- ○ Natural menopause
- ○ Hysterectomy no ovaries removed
- ○ Hysterectomy both ovaries removed
- ○ Hysterectomy one ovary removed
- ○ Hysterectomy, not sure about ovaries
- ○ Both ovaries removed, no hysterectomy
- ○ Chemo or radiation or hormone therapy
- ○ Unknown

If menopause NOT completed, do you have regular menstrual periods? ○ Yes ○ No

Interval between periods: [ ][ ] (days) Duration of periods: [ ][ ] (days)

Pregnancy History

Have you ever been pregnant? ○ Yes ○ No

If "Yes", please enter the following information:

How many pregnancies:	[ ][ ]	Total premature births:	[ ][ ]
How manyfull term deliveries:	[ ][ ]	Total number of abortions:	[ ][ ]
Age at first live birth:	[ ][ ]	Total number of miscarriages:	[ ][ ]

	Date of birth of each child	Did you breast feed this child
1.	[ ][ ] / [ ][ ] / [ ][ ][ ][ ]	○ Yes ○ No
2.	[ ][ ] / [ ][ ] / [ ][ ][ ][ ]	○ Yes ○ No
3.	[ ][ ] / [ ][ ] / [ ][ ][ ][ ]	○ Yes ○ No
4.	[ ][ ] / [ ][ ] / [ ][ ][ ][ ]	○ Yes ○ No
5.	[ ][ ] / [ ][ ] / [ ][ ][ ][ ]	○ Yes ○ No

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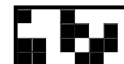

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

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8. Reproductive History (cont.)

Hormone Usage

Are you taking birth control or hormone replacement therapy?
○ Currently ○ Previously ○ Never

Which best describes your use of birth control/hormones?
○ Never used
○ Become pregnant
○ Maintain pregnancy
○ Prevent a pregnancy
○ Supplement after hysterectomy or oophorectomy
○ Help prevent osteoporosis
○ Regulate/control menstrual cycle/symptoms
○ Regulate/control menopausal symptoms
○ Unknown

Birth Control Use:
○ Oral contraceptive ○ Depo Provera (shot)
○ Nuva Ring ○ Ortho Evra (patch)
○ Other [ ]

Number of years used: [ ][ ] . [ ]

Hormone replacement therapy use:

Estrogen/Progesterone:	○ Yes	○ No	○ Previously	○ Unknown
Estrogen only:	○ Yes	○ No	○ Previously	○ Unknown
Progesterone only:	○ Yes	○ No	○ Previously	○ Unknown
Patch or topical/vaginal creams:	○ Yes	○ No	○ Previously	○ Unknown

Number of years used: [ ][ ] . [ ]

9. Family History

Mother:
○ Alive Age [ ][ ][ ] Illnesses: [ ]
○ Deceased Age at death [ ][ ][ ] Date of death [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
Cause of death [ ]

Father:
○ Alive Age [ ][ ][ ] Illnesses: [ ]
○ Deceased Age at death [ ][ ][ ] Date of death [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
Cause of death [ ]

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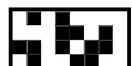

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number

U	S	F	-											

9. Family History (cont.)

Family history of benign (non cancer) breast conditions: ○ Yes ○ No ○ Unknown

If "Yes", please enter the details here

	Family member*	Age at diagnosis
1.		
2.		
3.		
4.		
5.		

Family member key

* Please use the following key when filling in "Family Member" information. Maternal refers to your mother's side of the family and Paternal refers to your father's side of the family.

1 = Mother
2 = Father
3 = Sister
4 = Brother
5 = Daughter
6 = Son
7 = Maternal grandmother
8 = Maternal grandfather
9 = Paternal grandmother
10 = Paternal grandfather
11 = Maternal aunt
12 = Maternal uncle
13 = Paternal aunt
14 = Paternal uncle
15 =Cousin (maternal or paternal)

Family history of other cancer (including breast cancer): ○ Yes ○ No ○ Unknown

If "Yes", please enter the details here (*please use the Family Member key at the top of this page)

	Family member*	Age at diagnosis	Status of family member	Type of Cancer:	Death due to cancer	Age of death
1.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
2.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
3.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
4.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
5.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
6.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	
7.			○ Alive ○ Dead ○ Unknown		○ Yes ○ No ○ Unknown	

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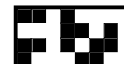

Comprehensive Breast Clinic
Clinical History

For Office Use Only

Patient ID Number: U S F - ☐☐☐☐☐☐☐☐☐☐☐

Reviewed by (please print): ☐

10. Review of Systems

Current weight (lbs.): ☐☐☐ . ☐ Height (inches): ☐☐☐ . ☐

Have you had a significant weight change of 10 pounds or more in the past year? ○ Gain ○ Loss ○ None

Please check all of the following that apply to you at this time:

General:
○ Recent weight loss ○ Fevers
○ Recent weight gain ○ Chills
○ Weakness ○ Poor appetite
○ Fatigue ○ Sleep poorly
○ NONE

Skin:
○ Rashes ○ Color changes
○ Lumps ○ Changes in hair or nails
○ Sores ○ Dryness
○ Itching ○ NONE

Head
○ Headaches ○ Head injury ○ NONE

Eyes:
○ Visual changes ○ Double vision
○ Glasses or contacts ○ Glaucoma
○ Pain ○ Cataract
○ Redness ○ Excessive tearing
○ NONE

Ears:
○ Hearing problems ○ Ear aches
○ Ringing in your ears ○ Infections
○ Vertigo ○ Discharge
○ NONE

Nose and Sinuses:
○ Frequent colds ○ Hay fever
○ Nasal stuffiness ○ Nose bleeds
○ Discharge ○ Sinus problems
○ NONE

Mouth and Throat:
○ Dental problems ○ Frequent sore throat
○ Bleeding gums ○ Hoarseness
○ Sore tongue ○ NONE

Neck:
○ Swollen lymph nodes ○ NONE
○ Enlarged thyroid (goiter)
○ Pain or stiffness

Breasts:
○ Lumps ○ Skin changes
○ Pain or discomfort ○ Fibrocystic disease
○ Nipple discharge ○ NONE

Respiratory:
○ Cough ○ Pneumonia
○ Asthma ○ Tuberculosis
○ Bronchitis ○ Pleurisy
○ Emphysema ○ NONE

Cardiac
○ Heart problems
○ High blood pressure
○ Rheumatic fever
○ Heart murmur
○ Chest pain or discomfort
○ Palpitations
○ Shortness of breath at rest
○ Shortness of breath with exertion
○ Shortness of breath lying flat
○ Swelling in your legs
○ NONE

Gastrointestinal:
○ Trouble swallowing
○ Heartburn
○ Decreased appetite
○ Nausea
○ Vomitting
○ Indigestion
○ Constipation
○ Diarrhea
○ Change in bowel habits
○ Rectal bleeding
○ Hemmorrhoids
○ Abdominal pain
○ Liver problems
○ Gall bladder problems
○ Hepatitis
○ Excessive belching or passing of gas
○ NONE

Urinary:
○ Frequent urination ○ Incontinence
○ Burning or pain ○ Stones
○ Blood in urine ○ Infections
○ Hesitancy ○ NONE

Peripheral vascular
○ Leg cramps ○ Varicose veins
○ Blood clots ○ NONE

Genitoreproductive

Female:
○ Abnormal vaginal bleeding
○ Painful intercourse
○ Vaginal discharge
○ Vaginal dryness
○ Hot flashes
○ Infections
○ Itching
○ Sores or lumps

Male:
○ Hernias
○ Penile discharge
○ Penile sores
○ Testicular pain
○ Testicular masses

○ NONE

Musculoskeletal:
○ Muscle pain ○ Back pain ○ Arthritis
○ Joint pain ○ Weakness ○ Gout
○ Fractures ○ Limited range of motion
○ NONE

Neurologic:
○ Fainting ○ Tingling
○ Seizures ○ Tremors
○ Paralysis ○ Involuntary movements
○ Numbness ○ NONE

Hematologic:
○ Anemia ○ Easy bruising or bleeding
○ Lymphoma ○ Leukemia/Polycythemia
○ Blood transfusion ○ NONE

Endocrine:
○ Thyroid problems
○ Heat or cold intolerance
○ Excessive sweating
○ Diabetes
○ Hypoglycemia (low sugar)
○ Excessive thirst
○ NONE

Emotional/Psychiatric:
○ Increased anxiety ○ Mood swings
○ Depression ○ Memory loss
○ Difficulty sleeping ○ Mental illness
○ Alzheimers disease ○ NONE

Autoimmune
○ AIDS ○ Lupus ○ NONE

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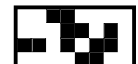


Breast Cancer Risk Assessment Worksheet

Institution ID Number | **Patient ID Number**

Date of Assessment ___ / ___ / ______   Date of Next Appointment ___ / ___ / ______

Primary risk factors:

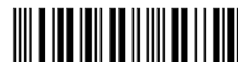
Note: The algorithm used is based on the Gail Model (1999), which is only valid for Caucasian or African American populations.

1. What is your ethnicity? ○ Caucasian/Non-black ○ Black
2. How old are you?
3. How old were you when you had your first period?
4. How old were you when your first child was born? (Enter 0 for none.)
5. Have any of your first-degree relatives (mother, sister, daughter) had breast cancer? ○ yes ○ no ○ don't know If yes, how many? (Enter 0 for none.)
6. How many breast biopsies have you had? (Enter 0 for none.)
7. Did any of the breast biopsies or HALO Breast PAP show atypical cells? ○ yes ○ no ○ don't know ○ not applicable

Additional risk factors:

1. Do you have a personal history of breast cancer? ○ yes ○ no ○ don't know
2. Do you or any family member have a BRCA 1 or BRCA 2 gene mutation? * ○ yes ○ no ○ don't know
3. Do you have a personal history of ovarian cancer? ○ yes ○ no ○ don't know
4. Do you have any nipple discharge? ○ yes ○ no ○ don't know
5. Are you of Ashkenazi Jewish background? ○ yes ○ no ○ don't know
6. Have any of your second-degree relatives (niece, aunt or grandmother) had breast or ovarian cancer? ○ yes ○ no ○ don't know
7. Do you have any relatives on your father's side with breast cancer? ○ yes ○ no ○ don't know
8. Are you postmenopausal with dense breasts? ** ○ yes ○ no ○ don't know

Fax Completed Forms to: 813-396-2494
(please be sure to return both pages)



Breast Cancer Risk Assessment Worksheet

Institution ID Number | | | | | | | | | | |

Patient ID Number | | | | | | | | | | | | | | | |

Notes:

When this form is faxed to the USF Breast Health Program, it is sent to a secure custom database. Risk calculations will be performed automatically and faxed back to the sending fax machine. Therefore, it is important to have your fax machine configured to receive return faxes. The data from page 1 will be sent back to you as it was interpreted by our system. Please verify the returned data for accuracy. The risk estimate will be returned on the bottom of page 2.

The Primary Risk Factors will be used to calculate the Five Year Risk, based on the Gail Model (1999). A 5 Year Risk of 1.7% or greater, is considered to be elevated and it is recommended a patient be referred to the USF Breast Health Program for more comprehensive assessment and counseling.

The Additional Risk Factors on page 1 are not included in the risk calculations, but are considered to be significant in assessing the risk of breast cancer. Therefore, if a patient has one or more of the Additional Risk Factors, it is recommended they also be referred to the USF Breast Health Program for further assessment. This is recommended even where the 5 Year Risk calculation is below the 1.7% threshold.

When referred to the USF Breast Health Program for a more comprehensive assessment, a complete history will be taken and all known risk factors will be recorded. A lifetime risk will calculated using additional algorithms such as BRCA Pro, Claus and Myriad. Using this data, an extensive risk assessment document will be generated which will include the risk calculations from all models, a genealogy chart, and a list of recommendations to help manage a high risk patient.

Any patient, whether low risk or high risk, who is interested in seeing a breast health care specialist should contact the USF Breast Health Program at 813-793-4272 for an appointment.

Please visit our web site at:
www.usfbreasthealth.org

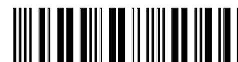
* If you or someone in your family has a BRCA1 or BRCA2 gene mutation, please tell your doctor so they can recommend appropriate services.

** Breast Density is usually measured when you have a mammogram, and will be included on the report your doctor receives from the imaging center. If you have had a mammogram, ask your doctor if the density measurement is 50% or more, or if the description says "heterogeneously dense" or "extremely dense". If so, your breasts are considered to be dense.

Please do not enter data here. The risk value will be calculated automatically after form verification. The risk value is only an estimate and you should consult your physician to discuss these results.

5 Year Risk: ☐☐.☐

Fax Completed Forms to: 813-396-2494
(please be sure to return both pages)



Hereditary Cancer Quiz www.hereditarycancerquiz.com/doctorcox

Take this quiz to find out your cancer risk

This brief questionnaire will help you determine whether you should be further evaluated for either Hereditary Breast and Ovarian Cancer syndrome or Lynch syndrome.

Don't forget to include BOTH your mother's and father's side of the family when answering questions. You will be assessed for the following hereditary cancers:

- breast cancer
- ovarian cancer
- colon cancer
- uterine cancer
- pancreatic cancer

These questions are based on the clinical guidelines doctors use to determine whether you should be tested for one of the above syndromes. This is not a test, but rather a questionnaire to help determine risk so you can be prepared to talk to your doctor about further evaluation of your personal and family history of cancer.

Start Now

By using the Quiz, you agree to be bound by the following Terms.

Your quiz results will automatically be sent to the healthcare provider that asked you to take the quiz. If you would like to share this quiz with your friends and family, please use the following link: www.hereditarycancerquiz.com

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MR Number

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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

Researchers at the University of South Florida (USF), study many topics. To do this, we need the help of people who agree to take part in research studies. The USF Breast Health Program, which is part of the USF Health system, has a specific research study we would like to ask you to take part in. It is called:

The Breast Care Database

The people who are in charge of this research study are:

Charles E. Cox, MD, FACS, Principal Investigator
Meira Pernicone, MD, Co-Investigator

The Breast Care Database study is being paid for by the Joy Culverhouse Breast Cancer Endowment fund and is supported by USF Health at the University of South Florida.

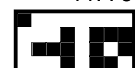
Purpose of the study

The purpose of this research study is to gather information about the health and care of patients that come in to the USF Breast Health Program. We would like to collect this information so we can assure the quality of current treatments and through future IRB approved research, help to develop new methods of diagnosis and treatment for future patients.

Study procedures

If you take part in this study, you will be asked to allow researchers at The USF Breast Health Program to collect and store your health information in a database called The Breast Care Database. The information collected and stored in the database is used to manage your current treatment and in research done at USF Health, with the approval of the IRB.

If you choose to participate in this study, we may contact other physicians that you see now, or that you will see in the future. We may also contact you by mail. This will allow us to get a complete and up-to-date record of your medical care and to follow up with treatment you may receive outside of the USF Breast Health Program.



MR Number

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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

Your health information will be kept in the Breast Care Database indefinitely. You will always have the option to withdraw your participation by notifying us in writing. If you withdraw your participation, we will no longer use your information for research purposes, but your information will remain in the Breast Care Database to help manage your ongoing care.

Benefits

You may not directly benefit by taking part in this database study. However, this study will help us to improve breast care now, and in the future, for all patients.

Risks or discomfort

There are no health risks by participating in this database study.

Will you be paid for taking part in this study?

You will not be paid for taking part in this database study.

What will it cost you to take part in this study?

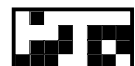
It will not cost you anything to take part in this database study. If, in the future, we contact you by mail, for updated health information, you will be provided with a stamped, self-addressed envelop.

Confidentiality of information used in the study?

Health information stored in the Breast Care Database is part of a University of South Florida Institutional Review Board (IRB) research protocol and as such is non-discoverable by law. It represents a secure repository of your healthcare information which cannot be shared with anyone, except with your permission. Therefore, any privileged information placed into this database is not available to insurance carriers or anyone else and cannot be used for solicitations.

Research at The USF Breast Health Program is conducted jointly with the University of South Florida (USF) and its affiliates. By signing this form, you are permitting USF, and its affiliates to use your personal health information for future IRB approved research within the USF health care system, collectively known as USF Health.

You are also permitting USF Health to share your personal health information with other individuals or organizations who are involved in IRB-approved research investigations. Sharing of information about people and their health is necessary for proper research. We know that this information is private and we will protect your health information at all times, as required by federal law.



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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

Who will see or use the information that you give?

USF Health, and the people and organizations listed below may review your information for patient care:

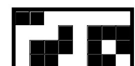
- The medical staff taking care of you.
- The research team, including the Principal Investigator, Study Coordinator, Research Nurses, and all other research staff.
- All health care and other USF Health staff who treat and serve you as a part of this research.
- Other research sites involved in this study. This includes all research and medical staff at each site.
- Any future research projects approved by the USF IRB.

The following may review your information to assure that the information meets local, state, and federal security standards:

- Agencies of the federal, state, or local government that regulate research. This includes the Food and Drug Administration (FDA), Florida Department of Health, Department of Health and Human Services (DHHS) and the Office for Human Research Protections.
- The USF Institutional Review Board and its related staff (who have oversight responsibilities for this study), staff in the USF Office of Research, USF Division of Research Integrity and Compliance, and other USF offices who oversee research.
- Data Managers and Clinical Trial Coordinators.

Who else can use this information?

Anyone listed above may use consultants or others to help them understand, analyze, and conduct this study. They are required to protect your private health information just as we are. However, once any information leaves USF Health, we cannot promise that others will keep it private. If we share any information, we will have a written contract with that organization stating that they will uphold the security of your health information as required by federal law.



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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

How will my information be used?

By signing this form, you are giving your permission to use your health information, as described in this document, for future IRB approved research. We may publish what we learn from research studies. If we do, we will not publish anything that would let people know who you are, either directly or indirectly. In addition, your information may be used to help manage your treatment, to collect payment for your treatment (when applicable) and to conduct regular business operations within the USF Health system. Your authorization to use your health information will not expire until the end of this research study, unless you revoke this authorization in writing.

What types of information will be used?

As part of this research, USF Health may collect and use the following information:

" Your complete health record.
" All of your past, current or future health records, held by USF, other health care providers or any other site affiliated with this study. This includes all information that is not protected by a Certificate of Confidentiality

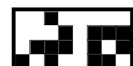
What if there is some information I want to keep private?

If you have any information that is protected by a Certificate of Confidentiality, for example, HIV/AIDS, mental health, substance abuse, and/or genetic information, it will not be included in our database without your permission. If you allow this, it will be stored with an additional level of security.

What rights do you have:

You have the right to refuse to sign this form. If you refuse:

" You will not be able to take part in this specific research project. However, this will not affect your care and treatment at USF Health in any way.
" This will not change your health care outside of USF Health.
" This will not change your health care benefits.
" This will not change the costs of your health care.



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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

How do I withdraw permission to use my information after I have already signed the form?

If you wish to withdraw from the study, you can do so in writing, by letter or e-mail. Please write or email to:

Dr. Charles Cox
USF Breast Health Program
3000 Medical Park Drive
Tampa, FL 33613
BreastProgram@health.usf.edu

If you choose to withdraw:

" Your health information will no longer be used in new research studies.
" If your health information is currently in use in a study before the date you withdraw, that information will continue to be used in those studies.
" Staff may follow-up with you, or your primary care physician, if there is a medical reason to do so.

Questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, call Dr. Charles E. Cox at (813) 793-4272, or the Study Coordinator, Nicole Howard, at (813) 793-4272 x 208.

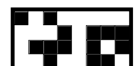
You may also email the Study Coordinator at BreastProgram@health.usf.edu.

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an adverse event or unanticipated problem call the Study Coordinator, Nicole Howard, at (813) 793-4272 x 208.

Consent/Research Authorization to Take Part in this Research Study

You should only take part in this study if you want to. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate and withdraw at any time. There will be no penalty or loss of benefits you are entitled to, and it will not affect your care and treatment in any way.



MR Number

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Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

Certificate of Confidentiality:

To help us protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. With this Certificate, we cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. We will use the Certificate to resist any demands for information that would identify you, except as explained below.

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of Federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA).

You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information.

I understand that by signing this form:

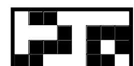
1. I am allowing my health information, as identified above, to be used in future IRB approved research studies.
2. I am allowing the research staff of this study to contact other physicians and care givers that I am seeing now or may see in the future, so that they may follow up with my health information, treatment and status.
3. I have received a copy of this form to take with me.

Signature of Person Taking Part in Study

Date

__ __ / __ __ / __ __ __ __

Printed Name of Person Taking Part in Study



MR Number

U	S	F	-										

Informed Consent/Research Authorization to Participate in Research

Information to Consider before Taking Part in this Research Study

Statement of Person Obtaining Informed Consent/Authorization

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the research study is about.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research study. This person speaks the language that was used to explain this research study.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

Date

__ __ / __ __ / __ __ __ __

____

Signature of Person Obtaining Informed Consent/Authorization

____

Printed Name of Person Obtaining Informed Consent/Authorization

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

National Institutes of Health
National Cancer Institute
Bethesda, Maryland 20892

CONFIDENTIALITY CERTIFICATE

NCI-08-047

issued to

University of South Florida

conducting research known as

"The Breast Cancer Database"

In accordance with the provisions of section 301(d) of the Public Health Service Act 42 U.S.C. 241(d), this Certificate is issued in response to the request of the Principal Investigator, Dr. Charles E. Cox, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Dr. Cox is primarily responsible for the conduct of this research.

Under the authority vested in the Secretary of Health and Human Services by section 301(d), all persons who:

1. are enrolled in, employed by, or associated with the University of South Florida and its contractors or cooperating agencies, and

2. have in the course of their employment or association access to information which would identify individuals who are the subjects of the research pertaining to the project known as "The Breast Cancer Database"

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

APPROVED
USF INSTITUTIONAL
REVIEW BOARD FWA00001669

The purpose of this study is to gather information about the health and care of patients that come in to the Comprehensive Breast Clinic.

All patients with a diagnosis of a breast-related malignant or benign disease, including cancer or fibrocystic disease, are eligible for entry into the breast care database.

A Certificate is needed because sensitive personal and medical information will be collected from subjects for research purposes during the course of this study. This Certificate will help researchers avoid involuntary disclosure, which could expose subjects and their families to adverse economic, psychological, and social consequences.

Data will be stored on private servers which are connected to the existing network of the University of South Florida. Only authorized users will be able to log on to the network before the database can be accessed.

This research began on 6/21/2004 and ends on 6/21/2014.

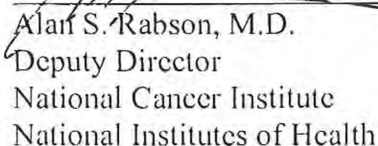
As provided in section 301(d) of the Public Health Service Act 42 U.S.C. 241 (d):

> "Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This Certificate does not protect you from being compelled to make disclosures that: (1) have been consented to in writing by the research subject or the subject's legally authorized representative; (2) are required by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or regulations issued under that Act; or (3) have been requested from a research project funded by NIH or DHHS by authorized representatives of those agencies for the purpose of audit or program review.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services. This Certificate is now in effect and will expire on 6/21/2015. The protection afforded by this Certificate of Confidentiality is permanent with respect to any individual who participate as a research subject (i.e., about whom the investigator maintains identifying information) during any time the Certificate is in effect.

Date 12/4/08



Alan S. Rabson, M.D.
Deputy Director
National Cancer Institute
National Institutes of Health

APPROVED
USF INSTITUTIONAL REVIEW BOARD FWA00001669

USF Health
Release of Information Department

12901 Bruce B. Downs Blvd MDC 33 · Tampa, FL · 33612
Phone (813) 974-9818 · Fax (813) 974-4280

Authorization to Release Medical Records, PHI, to Additional providers, family member, Friend and/or Organization.

Patient Name:____

DOB_____________ Social Security Nimber__________________________

Medical Record Number______________________

I authorize release of PHI as defined under "HIPAA" as described on the attached authorization form to the following person(s), family member, physicians(s) and or organization(s):

Name of person(s) or Physician(s) ______________________________

Relationship to patient ______________________________________

Street address: ____

City, State and zip code______________________________________

Telephone number: ____

Fax number: ____

Purpose: ____

____________________________ ________________________
Signature of patient or personal representative Date

____
Printed name of **patient** or **personal representative** (circle one)

____
Relationship to patient giving representative authority to act for patient

Patient or personal representative was given a copy of this form. YES______NO_____

*USFPG Staff member completing this process*___________________________________

*Date*_______________

USF Physicians Group

UNIVERSITY OF SOUTH FLORIDA

Authorization to Records Custodian

RELEASE OF INFORMATION

Patient's Name____ Date of birth______________________________

Patient's Social Security No. _______________________________ Medical Record No. _________________________

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Release to: ______________________________	Obtain from: ______________________________
Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

Purpose: ____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting) Initial next to A, B, or C

A. _______ALL records in the custody of USF/USF Physicians Group

B. _______ALL records in the custody of _________________________

C. _______ONLY the following: (Check records being requested)

_____Records of the treating physician __________________only

_____Evaluation Initial

_____Follow Up Notes

_____Medication Report

_____Most Recent Discharge Status

_____Discharge Summary

_____Hospital Admission History and Physical

_____X-rays

_____Lab Results

_____Other____

I understand that I may be charged for the copying of these patient records and payment is expected at the time the copies are received from the University of South Florida/USF Physicians Group.

If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or behavioral health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501.

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida before the University received my written notice of revocation.

This authorization form expires on ______________ or when __________________ occurs.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida or _________________________. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.

I understand that I may refuse to sign this form.

There is a potential that the PHI may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.

______________________________	______________________________
Signature of patient or personal representative	Date
Printed name of **patient** or **personal representative**	Relationship to patient giving representative authority to act for patient