Aaron G. Margulies MD
Compassionate surgical care you can trust

Clinical Genetics Service

Helping You and Your Family Reduce Your Risk

Your appointment is ______________________________ at ________AM/PM

☐ **North Office Location**
7714 Conner Road
Suite 107
Knoxville, TN 37849

☐ **West Office Location**
Tennova Turkey Creek
Medical Center
10810 Parkside Drive, G-11
Knoxville, TN 37934

☐ **Morristown Location**
420 W. Morris Blvd
Suite 400 C
Morristown, TN 37813

Dear ____,

Thank you for your interest in the Clinical Genetics Service. I look forward to working with you to evaluate your risk for breast cancer and to develop approaches to reduce your risk for breast cancer. Our service also includes risk assessment for those with breast cancer, ovarian cancer, colorectal cancer, uterine cancer and other cancers to assess the role genetics may play in cancer development.

In an effort to expedite your visit, please complete the attached questionnaire packet and return it at your scheduled appointment. In addition, if you or anyone in your family has already pursued hereditary cancer genetic testing, it is very important that you bring a copy of the test result to your appointment, if possible. If appointment not scheduled above, I will contact you to schedule an appointment convenient for you.

During your visit we will review your personal and family history and your lifestyle questionnaire to assess whether a hereditary cancer syndrome may explain some of the cancers in your family. We will discuss the basic genetics of hereditary breast and ovarian cancer syndrome (HBOC) and other cancer syndromes as appropriate and discuss strategies for an individualized healthcare plan for cancer risk reduction. If genetic testing is indicated, then cancer predisposition gene testing can be initiated at the end of the appointment via a blood sample. Insurance coverage and the testing laboratory's pre-authorization process will be discussed at your appointment.

Early Detection and Risk Reduction are our Key Goals in the Clinical Genetics Service.

If your insurance requires a referral from your primary care physician, then please ensure that a referral is completed prior to scheduling your appointment. All other charges will be filed with your insurance.

If you have any questions or need further assistance, please give me a call at **865-692-1602.**
I look forward to meeting with you soon.

Sincerely,

Imelda G. Margulies, MSN, FNP- BC
Director, Clinical Genetics Service

Name:________________________________ Date of Birth: ___________________ MRN: _______

How many sisters do you have? _________________ How many brothers? ___________________

How many children do you have? ________________ Daughters ____________Sons ___________

How many sisters does your mother have? ________ How many brothers? ___________________

How many sisters does your father have? _________ How many brothers? ___________________

Ethnic background: ____________________________ Ashkenazi Jewish? YES / NO

PLEASE LIST ALL MEMBERS OF YOUR FAMILY ALIVE OR DECEASED REGARDLESS OF CANCER

*Indicate who in your family (including yourself) has had Cancer **- (Especially breast, ovarian, pancreatic, and prostate)**

ie: Mother Susan Breast 45 Well at 58 or Died at 55

RELATIVE	FIRST NAME	CANCER TYPE	AGE at DIAGNOSIS	STATUS-alive (age)	STATUS-deceased (age)
You					
Daughter					
Daughter					
Son					
Son					
Your Family					
Sister					
Sister					
Brother					
Brother					
Mother					
Father					
Mother's Side					
Grandmother					
Grandfather					
Aunt					
Aunt					
Uncle					
Uncle					
Father's Side					
Grandmother					
Grandfather					
Aunt					
Aunt					
Uncle					
Uncle					

If you have a large family history of cancer, please list on the back of this sheet additional family members (cousins, etc.) that may provide more accurate information regarding your family history of cancer.

Name:______________________________ Date of Birth: __________________ MRN: _______

Referred by: ___________________________ Primary Care Physician: _______________________

1. How many times have you been pregnant? (Include miscarriages & abortions)____________________
2. How many children have you delivered? ____
3. At what age did you have your first child? ____
4. Are you currently pregnant or planning to become pregnant in the next 5 years? __________________
5. If not pregnant, are you still having monthly periods? _________________Date of LMP__________
6. How old were you when you had your first period? _______________________________________
7. If you are postmenopausal or no longer having periods, how old were you when you stopped having them? ____________________________________
8. Has your uterus been removed (hysterectomy)? Yes No
   If yes, at what age? ________________________
9. Have both your ovaries been removed? Yes No
   If yes, at what age? ________________________
10. Have you ever taken Birth Control Pills? Yes No
    If yes, are you currently taking them? ___________
    How long did you take them? ________________
11. Have you ever taken Hormones (Premarin ,estrogen…)? Yes No
    If yes, are you still taking them? _______________
    How long did you take them? ________________
12. Are you having any menopausal symptoms (hot flashes, mood swings, etc.? Yes No
13. When was your last Pap smear? ____________ Last pelvic exam? _________
14. Have you ever been diagnosed with any type of female cancer? Yes No
    If yes, what type? ____
15. What is your height? ____
16. How much do you weigh? ____

BREAST HISTORY

1. Do you perform monthly breast self-exam? Yes No
2. When was your first and last mammogram? ____
3. Where was it done? ____
4. When was the last time you had a clinical breast exam by a healthcare professional? ________________
5. Do you have a history of fibrocystic changes of the breast? Yes No
6. Have you ever been diagnosed with a fibroadenoma of the breast? Yes No
7. What do you think is your risk of getting breast cancer?
   ______very low _______average _______ higher than average ______ very high
8. How concerned are you about your risk of getting breast cancer?
   _____not at all _____rarely worry ____occasionally ____very worried _____worry constantly
9. Have you ever had surgical breast biopsies? Yes No
   If yes, how many? _________________________
   What were the results of your breast biopsy? ____________________________________
10. Have you ever been diagnosed with Atypical Hyperplasia? Yes No
11. Have you ever had a colonoscopy? Yes No
    If yes, Date / Results / #of Polyps: ____

Name:______________________________ Date of Birth: __________________ MRN: _______

GENERAL MEDICAL HISTORY

PLEASE LIST ALL ILLNESSES, HOSPITALIZATIONS AND SURGERIES:

DATE	ILLNESS	SURGERY	DOCTOR	RESULTS	OTHER

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	PRESCRIBED BY	HOW LONG ON MEDICINE	SIDE EFFECTS OF MEDICINE

MEDICATION HISTORY:

1. Do you have any allergies to medicines /food / other? ☐ NKDA ________________________________
2. Have you ever taken anti-coagulation therapy? Yes No
   If yes, what medications? ___________________________________
   How long? ____
3. Have you ever had any type of blood clot? Yes No
4. Have you ever had a blood clot in your lung (pulmonary embolism?) or in a major vein (deep vein thrombosis)? Yes No
5. Do you take Aspirin daily? Yes No
6. Do you take Ibuprofen daily? Yes No

Name:______________________________ Date of Birth: __________________ MRN: ______

LIFESTYLE QUESTIONNAIRE:

1. What is the highest level of schooling you completed?
   ____Grade School____ High School ______College ______Graduate School
2. Do you currently smoke cigarettes? __________________________________ Yes No
   If yes, how many cigarettes a day do you smoke? __________________________________
3. Do you drink alcoholic beverages? Yes No
   If yes, how many per week? __________What type of alcohol? ________________________
4. Do you exercise routinely? ____ Yes No
5. How many hours of vigorous exercise per week? ____
6. What type of exercise do you do? ____
7. What type of diet do you normally eat? ____
8. Do you eat a diet high in fat? ____
9. How many vegetable servings do you consume daily? ____________________________________
10. Describe what a routine day of food would consist of:

    BREAKFAST:

    LUNCH:

    DINNER:

    SNACKS:

BREAST CANCER RISK SURVEY: GAIL MODEL

1. Have you ever had breast cancer? ____ Yes No
   If yes, you have completed this page. Please stop here.
2. How old are you? ____
3. How old were you when you had your first menstrual period? _______________________________
4. How old were you when your first child was born? (If you never had a child, enter "0") _____________
5. How many of your sisters, daughters or mother had breast cancer? _____________________________
6. Have you ever had a breast biopsy? Yes No
   (A breast biopsy is when a doctor removes tissue from the breast to test for cancer)
   If yes, how many breast biopsies have you had? ______________________________________
7. Did any of your biopsies show atypical hyperplasia? (a precancerous condition) Yes No
8. Did any of your biopsies show lobular carcinoma in situ (LCIS) or ductal carcinoma in situ (DCIS)?
   Yes No

Aaron G. Margulies, MD, PLLC

Aaron G. Margulies, MD, FACS

Imelda Margulies, MSN, FNP-BC

FINANCIAL RESPONSIBILITY FORM

At the office of **Aaron G. Margulies, MD, PLLC**, we strive to give you the best possible care. In order to serve this purpose, it is important that our patients understand the process of reimbursement. Please read this Financial Responsibility Form and sign to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payment due will be yours.

***If you have any changes in your insurance coverage you must notify us prior to your appointment.**

DEDUCTIBLES, COINSURANCE AND COPAYMENTS

The deductible is determined by your individual contract with your insurance carrier. You are responsible for your deductibles, copayments, and coinsurance. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay deductibles, coinsurance and copayments, when this applies.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for account balances if their insurance carrier denies payment for services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary.” To avoid this, please check with your insurance carrier prior to receiving any treatment or services.

By signing below, I authorize the release of any medical information necessary to process insurance claims filed to my insurance carrier on my behalf or on the behalf of my dependents. I authorize payment for medical benefits to be made directly to my physician for services rendered at the office of **Aaron G. Margulies, MD, PLLC**.

I certify that I have read the above disclosure statements, understand my responsibilities, and agree to the terms written above.

Patient / Responsible Party Signature: ____**Date**_____________

Patient / Responsible Party Name (Please Print) ____

Relation to Patient: ____

Patient Demographic Information

Full Name: __________________________________Middle Initial______

DOB: _______/________/__________ SS#: ________-______-________

Address: __________________________________ City: ______________________ State: _______ Zip Code: ___________

Phone Numbers

Home: (_____) ______________________________

Mobile: (_____) ______________________________

Work: (_____) _______________________________

Email: ______________________@______________

Preferred Method of Contact:

Home ☐ Mobile ☐ Work ☐ E-Mail ☐

Marital Status: __________________

How did you hear about us? ____________________

Do you consent for our office to leave a voice message if needed? **Yes** **No**

Would you like an email invite to register an account on our patient portal? **Yes** **No**

Would you like an email for sign-up information to Dr. Margulies' blog on Breast Cancer? **Yes** **No**

Insurance ***If your insurance carrier through your spouse or someone else please complete the following:**

Name of Insured: ____________________________________ Relation: ______________________

DOB: _______/________/__________ SS#: ______-_____-_______

Emergency Contacts

1. __________________________________ Relation: _____________ Phone: ___________________________________
2. __________________________________ Relation: _____________ Phone: ___________________________________

*May we contact and share medical information with your emergency contacts if needed? **Yes** **No**

Treating Physicians: Primary Care Physician: _____________________ Referring Physician: __________________________

Medical Oncologist: ________________________ Radiation Oncologist: ________________________

Gynecologist: ______________________ (if applicable)

Pharmacy: Name: _________________________________ City: _______________ Phone: ____________________

If you are a **Breast Care Patient**, do you give consent for Dr. Margulies to discuss your case with other physicians? **Yes** **No**

If you are a **Genetics Patient**, do you give consent for our office to release or obtain copies of your genetic testing? **Yes** **No**

By signing below, I verify that all of the information above is correct. I also verify that I have been offered and have reviewed a copy of the Patient Privacy Notice required by HIPAA, and understand my right to privacy as a medical patient of Aaron G. Margulies MD, PLLC.

Patient / Responsible Party Signature: ______________________________________ Date: ___________________