Carol Slomski, MD, FACS
Breast Surgeon
Weirton Office:
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Weirton, WV 26062
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400 Marketplace Drive
Oakdale, PA 15071
T- 724-218-1782

Dear ____________________________,

Your Appointment is scheduled for: _________________ @ ____________ AM / PM

Welcome to Weirton Medical Center, office of Carol Ann Slomski, MD. Enclosed you will find paperwork needed for the day of your visit. Please complete these forms before your appointment. Please try your best to return them to our office. You can either choose to drop them off or mail/fax them ahead of your appointment.

Please bring the following to your appointment:

- ☐ Completed new patient paperwork. Please drop it off or mail/fax it ahead of time if possible.
- ☐ Insurance/Medical Card(s), Insurance Referral (if required by your insurance company), and Photo Identifications such as: Driver's license, passport, military or any other state issued ID
- ☐ Co-payment (if applicable) in cash/check/credit/FSA/HRA
  Exact change is most appreciated and check can be made out to WMC PPI
- ☐ Hand-carry your most recent mammogram/sonogram/MRI films with reports if performed at a facility other than Weirton Medical Center. Films or CD's are acceptable. This is not required if films were obtained at Weirton Medical Center. If your films are not available for the doctor to review at the time of your appointment, it may need to be rescheduled.
- ☐ Questions you may have and want to ask. Please feel free to bring a friend/relative for support and questions.

Any questions, please do not hesitate to contact our office.

What to expect your first visit

What to expect at your first visit to our office:

- Prior to your visit you will be asked to fill out a questionnaire about your medical history. It is important that we have an accurate record of any medical condition that you might have. We'll want to know about any symptoms you might be experiencing now. We'll also want to know about any operations you may have had. Please tell us if you are allergic to anything and bring a complete list of prescription medications, over the counter medications and any herbal medications or vitamins you may be taking. Include the dose and how long you have been taking them.
- When you arrive at the office you'll be given several documents to read and sign. You will be asked to sign a copy of our privacy policy; medical records release form, and provide a copy of your insurance information card and some demographic information.
- When you are taken to the exam room our nurse will ask you for clarifications about your medical conditions, medications and the reason for your visit. Your heart rate, blood pressure and temperature will be recorded. You will be asked to disrobe from the waist up and given a cape or gown to wear.
- Your doctor will ask you questions about your medical history, your risk factors for breast cancer and the specific concerns that you are being seen for. It is important to provide as much information as possible.
- Your exam will start with an inspection of your breasts in the seated position and with your arms raised above your head and your chest muscles flexed. This allows your doctor to look at the symmetry of your breasts and to check for any skin dimpling or retraction which could be a sign of breast cancer. Next the lymph nodes in your neck and axillary (underarm) areas will be examined. Your doctor will be checking to see whether any of the lymph nodes in these areas are hard or enlarged. Finally, while you are lying down your doctor will examine your breasts. You may be asked to point out any areas of your breasts that are of concern to you.
- After the exam your doctor will review your mammograms, ultrasounds and any other test results you might have with you. It is important to bring these films to your visit.
- The doctor will discuss your situation with you and recommend a treatment plan or may offer you general options. It's important to ask questions at this point so that you can fully understand the options presented to you and make a decision about your treatment that is right for you. If you have done any reading such as research on the internet, you might have questions, concerns or thoughts about your treatment. Now is the time to bring these up. The internet is a wonderful resource but not all of the information found will apply to you. Your doctor will help you sort this out.
- After your visit your doctor will record the visit in your chart. A copy of this note and the results of your tests will be sent to your primary doctor. Please be sure that we know which doctors should receive this information.
- Our reception staff will assist you in making follow up appointments, or scheduling tests and surgery if the doctor determines this is necessary.

BREAST CARE PATIENT PROFILE

LEGAL NAME: ___________________________________ NAME YOU PREFER: ____________________

Birthdate: ________________ Age: _______ Height: ________ Weight: _________ Occupation: __________

PRIMARY DOCTOR: _____________________ REFERRING DOCTOR: ____________________________

GYNECOLOGIST:________________________ CELL PHONE:___________________________________

HOME PHONE: _____________________ MAY WE LEAVE A VOICEMAIL? _______________________

SS#:______________________________ EMAIL ADDRESS: _______________________________________

RACE: (Circle one) American/Indian/Alaska Native Asian Black/African American More than 1 Race

Native Hawaiian Pacific Islander White Other/Unknown

ETHNICITY: Hispanic/Latino Not Hispanic/Latino **PREFERRED LANGUAGE:** English Spanish Other

PREFERRED PHARMACY NAME AND ADDRESS: ____

PHONE: ____

REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS/FOOD/LATEX/OTHER

____

____

HAVE YOU EVER SEEN DR. SLOMSKI? YES NO If "YES", When? ____________

THIS SECTION IS ABOUT YOUR FAMILY'S HEALTH

FAMILY BREAST HISTORY

If you have a history of breast cancer in your blood relatives, please complete the following section.

Relationship	**One Breast**	**Both Breasts**	**Age of Diagnosis**	**Treatment Received**	**Alive**	**Deceased**
Grandmother						
Mother						
Sister(s)						
Daughter(s)						
Aunt(s)						
Father						
Brother(s)						
Son(s)						
Grandfather						

Patient initials: _______ Physician initials: _________

Name ________________________

FAMILY HISTORY – Other medical Conditions (Blood relatives only; mother, father, sibling, aunt, uncle, etc.)

Disease	Relationship	Disease	Relationship
Cervical Cancer		Other Cancer	
Ovarian Cancer		Colon Polyps	
Colon Cancer		Coronary Heart Disease	
Liver Cancer		Thyroid Disease	

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (Circle all the apply)

- Anesthesia Complications
- Antibiotic use prior to procedures
- Asthma
- Atrial Fibrillation
- Blood Transfusion
- Breast Cancer
- Breast Disease
- COPD
- Cancer other than Breast: ______________________

- Coronary Heart Disease
- Chronic Renal Failure
- Cirrhosis
- Colon Cancer
- Crohn's Disease
- Deep Vein Thrombosis
- Depression
- Diabetes – Type1
- Diabetes – Type 2
- Diverticulitis
- GERD

- Hepatitis ABA
- High Cholesterol
- High Blood Pressure
- Hypothyroidism
- Hyperthyroidism
- IBS
- Kidney Disease
- Kidney Stone
- Morbid Obesity
- MRSA
- Mitral Valve Prolapse

- Osteo Arthritis
- Rheumatoid Arthritis
- Osteoporosis
- Osteopenia
- Pancreatitis
- Peripheral Vascular Disease
- Pulmonary Embolism
- Seizure Disorder
- Tuberculosis
- Valvular Heart Disease
- Varicose Veins/Phlebitis
- VRE

YOUR PAST BREAST HISTORY

Do you have any history of non-cancerous breast problems? (I.e. fibrocystic changes, mastitis, etc.) YES NO

If yes, describe: ____

Have you had any procedures/operations or needle biopsies on your breast(s)? YES NO

If yes, complete this section

Date	Breast	Type of Operation	Hospital City/State	Surgeon
	R L			
	R L			
	R L			

Have you ever been diagnosed with breast cancer? (If yes, check ALL treatments listed below that apply) YES NO

	Mastectomy (Surgical removal of breast)		Radiation treatment to breast
	Lumpectomy or Wide Excision of lump only		Radiation to chest wall after breast removal
	Chemotherapy		Hormone Therapy (i.e. Tamoxifen)
	Other		

Have you ever received radiation (cobalt) treatments to face, tonsils, skin or thymus for cancer? YES NO

If yes, how much? ____ How Long? ________________________

PLEASE LIST ANY OTHER PREVIOUS SURGERIES OR HOSPITALIZATIONS, INCLUDING DATES

Patient initials: __________ Physician initials: ___________

Name ________________________

SOCIAL HISTORY

Tobacco Use: **YES** **NO** QUIT Year Started: _______ Year Quit: ______ How much per day_______

Alcohol Use: **YES** **NO** How much per day __________________________________

Use of cocaine, marijuana, heroin, steroids, pills **YES** **NO** History of treatment for substance abuse **YES** **NO**

Hit Slapped or Kicked in the past year: **YES** **NO** Sexually abused in the past year **YES** **NO**

Do you have any religious beliefs which would affect care? **YES** **NO**

Please describe____

GYNECOLOGICAL HISTORY INCLUDING PREGNANY AND BIRTH

Age you began menstruating _______ Are you still menstruating ________ Did you stop naturally? ________

Have you had surgery to remove your uterus (womb)? __________

Have you had surgery to remove your ovaries? _________

Number of pregnancies __________ Number of completed deliveries _________ Age at first delivery _______

Have you ever taken estrogens or hormonal pills? ________ If yes, how long? _______ Name ______________

Have you ever taken birth control pills? If yes, how long? _________ Name of medication_________________

PLEASE CIRCLE ANY CONDITIONS THAT APPLY TODAY OR ON AN ONGOING BASIS

GENERAL **No Concerns** Fever / Loss of appetite / Weight loss / Fatigue / Anemia	**SKIN** **No Concerns** New skin lesions / change in mole(s) / Rash / Itching / History of skin cancer / Change in wart or mole / Suspicious lesions
HEAD/EYE/EAR/NOSE/THROAT **No Concerns** Decreased hearing / Mandibular/jaw fracture / Nasal fracture / Dentures / Glaucoma / Cataracts / Blurred vision / Frequent headaches / Eye Injury / Sore Throat	**NECK** **No Concerns** Neck swelling / Goiter / Thyroid problems
RESPIRATORY/LUNGS **No Concerns** Cough / Shortness of breath / Wheezing / pain with breathing / Asthma / COPD / Use of Oxygen	**BREAST** **No Concerns** Breast pain / left breast lump / right breast lump / Bloody nipple discharge / Breast enlargement / Nipple inversion / Abnormal mammogram
HEART/CIRCULATION **No Concerns** Chest pain / irregular heart beat / Fainting or black out spells / swelling of arms or legs / Stents / Heart Surgery / History of heart attack	**STOMACH/DIGESTION** **No Concerns** Abdominal pain / Nausea / Vomiting / Diarrhea / Constipation / Change in bowel habits / Black tarry stools / Blood in stools / Hepatitis / Gas / Bloating / Indigestion-heartburn / difficulty swallowing / painful swallowing
FEMALE GENITOURINARY **No Concerns** Vaginal discharge / Abnormal vaginal bleeding / Pelvic pain / Incontinence / Painful urination / blood in urine / Urinary frequency / Nocturia / Urinary hesitancy / Pregnancy / Menopause / Date of last menstrual period: _____________	**MUSCULOSKELETAL** **No Concerns** Arthritis / Back pain / Sciatica
NEUROLOGICAL **No Concerns** Paresthesians / Seizures / Dizziness / Frequent headaches / history of Alzheimer's / History of stroke / Head injury / Paralysis	**PSYCHIACTRIC** **No Concerns** Depression / Anxiety / Memory loss / thoughts of suicide / Claustrophobia / Hallucinations
ENDOCRINE **No Concerns** Heat intolerance / Cold intolerance / hair loss / unusual weight change / exposure to radiation	**HEMATOLOGY** **No Concerns** Abnormal bruising / Abnormal bleeding / Enlarged lymph nodes / Anticoagulation / Transfusion / Anemia

____________________________________ ____________________________________

PATIENT SIGNATURE **DATE** **DR/NURSE SIGNATURE** **DATE**

Name ___________________________

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING BIRTH CONTROL AND ANY OVER THE COUNTER MEDS SUCH AS ASPIRIN, TYLENOL, VITAMINS, ETC (include dosage)

MEDICATION	DOSAGE	FREQUENCY

Patient initials: ____________ Physician initials: ____________

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________________ Physician: ______________________________

Date Completed: ______________________________ Date of Birth: ______________________________

Please mark below if there is a personal or family history of any of the following cancers. If yes, indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age	SIBLINGS/ CHILDREN	Age	MOTHER'S SIDE	Age	FATHER'S SIDE	Age
For Example: Colorectal Cancer	*none*	-----	*Brother*	*36 yrs*	*Aunt* *Cousin*	*44 yrs* *58 yrs*	*Grandfather*	*65yrs*
BREAST AND OVARIAN CANCER								
Breast Cancer								
Ovarian Cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish decent ☐ Yes ☐ No

COLON AND UTERINE CANCER

	YOU	Age	SIBLINGS/ CHILDREN	Age	MOTHER'S SIDE	Age	FATHER'S SIDE	Age
Uterine (endometrial) Cancer								
Colorectal Cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
10 or more cumulative colon polyps								

MELANOMA

	YOU	Age	SIBLINGS/ CHILDREN	Age	MOTHER'S SIDE	Age	FATHER'S SIDE	Age
Melanoma								
Pancreatic Cancer								

	YOU	Age	SIBLINGS/ CHILDREN	Age	MOTHER'S SIDE	Age	FATHER'S SIDE	Age
OTHER CANCER ______________________								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________________

Authorization for Release of Protected Health Information

Patient Name: ____
Last Initial First

Date of Birth: ______________________________

Address: ____

TO: ____

I have been a patient (or I am the patient's authorized representative). I understand that you have legally protected health information about me (or the person I represent). I understand that signing or not signing this form will not affect treatment I receive in any way.

I hereby authorize you to release to:

WEIRTON MEDICAL CENTER / Carol Ann Slomski, MD. FACS

651 Colliers Way Suite 307 **Weirton WV 26062** **Office #: 304-797-6433** **Fax #: 304-797-6601**	**400 Market Place Drive** **Oakdale, PA 15071** **Phone #: 724-218-1782**

The following information: (place a check by types of records desired)

___ Allergy list
___ Hospital documents (H&P, op notes, discharge summary, etc.)
___ Lab Results
___ Radiology Results (x-ray, CT, MRI, etc.)
___ Medication list
___ Problem List
___ The above information and/or the entire Medical Record which includes HIV-related information
___ The above information and/or the entire Medical Record including mental health, drug or alcohol treatment
___ Entire Medical Record **EXCLUDING** HIV-related, mental health, drug, or alcohol treatment
___ Billing or other business records (specify):____
___ Other (specify):____
From (date): ____________________________ to (date): ________________________
(specify) (specify)

Reason for request:
__ Continuing treatment ___ Insurance ___ Legal ___ Employer ___ Study/Research ___ Second Opinion
__ Other ___________________________________ ___ **I do not wish to disclose the reason**

This authorization will expire in 6 months or: ____
(Specify expiration date, event, or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to extent that you already taken action in reliance upon it. A photocopy of facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may re-disclose information which I have authorized them to receive.

_____________________________ ___________________ _________________________ ______________
Patient or Representative Signature Date Witness Date

Dear Patient

In an attempt to serve you better at Weirton Medical Center, please complete the below information.

Pain Screening	Yes	No
Do you have pain today?	________	________
Where is your pain located?	______________________________	
How long have you had the pain?	______________________________	
What have you done to make your pain go away?	______________________________	
Rate your pain on a (0-10) scale with 10 being the worst pain	________	

Functional Screening	Yes	No
Have you thought about hurting yourself within the last few months?	________	________
Has someone hurt you recently or in the last year?	________	________
Have you had a change in your appetite/nausea/vomiting/diarrhea recently?	________	________
Have you had a recent decline with walking or performing your daily activities?	________	________
Do you need help with finances, transportation or basic care?	________	________

Education

Do you need education on any of the following?

Medication	Yes	No
Equipment or Supplies	Yes	No
Pain Management	Yes	No
Treatment Plan	Yes	No
Nutrition	Yes	No
Rehabilitation	Yes	No
Health Practices or Safety	Yes	No
Oral Hygiene	Yes	No

Birthdate______________________

________________________________ ______________ ________________
Patient Signature Date Time

________________________________ ______________ ________________
Information Reviewed by Date Time

Comments/Follow-up

____
____
____
____

Fall Risk Assessment Form

1. Are you age **65 or older**? Yes or No
2. Do you have **3 or more diagnosis**? Yes or No
3. Do you have a prior history of **falls within the last 3 month**? An unintentional change in position resulting in coming to rest on the ground or at a lower level. Yes or No
4. Do you have **incontinence**? An inability to make it to the bathroom or commode in a timely manner. Includes frequency, urgency, and/or nocturia. Yes or No
5. Do you have **visual impairment**? Includes macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription. Yes or No
6. Do you have **impaired functional mobility**? May include needing help with ADLs or have a gait or transfer problem, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices. Yes or No
7. Do you have **environmental hazards**? May include poor illumination, equipment tubing, and inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered or outdoor entry and exits. Yes or No
8. Do you have **4 or more prescriptions**? Yes or No
9. Do you have **pain affecting your level of function**? Yes or No
10. Do you have **cognitive impairment**? Could include dementia, Alzheimer's, stroke, confused, use poor judgment, decreased comprehension, impulsivity, memory defects. Yes or No

Name ____

Birthdate ____

Staff Signature and date _________________________________

Weirton Medical Center

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Special MSO and Integrated Practice Networks' Notice of Privacy Practices ("Notice"). I understand that information the **ASPN-Weirton Medical Center** acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

____ ____

Signature Date Witness Date

_______________________ Patient _____________________ Substitute Decision Maker

____ ____

If Substitute Decision Make, state relationship If Substitute Decision Maker, state reason

Weirton Medical Center
Carol A. Slomski, MD, FACS

PATIENT CONFIDENTILITY NOTICE

PATIENT NAME ________________________________ DATE OF BIRTH ________________________
(Please Print)

PLEASE CHECK APPROPRIATE ITEMS

___ List the family members or other persons, if any, whom we MAY inform about your general medical condition and your diagnosis

____
____
____

___ List the family members or other persons, if any, whom we MAY inform about your medical condition ONLY IN AN EMERGENCY

____
____
____

___ List the family members or other persons, if any whom ARE authorized to pick up on your behalf, healthcare information such as medical records, prescriptions, tests results, etc.

____
____
____

____ ____
Signature of Patient (or Guardian) **Date**