Patient History Form

Please complete this questionnaire before your appointment. Please email back to our office or bring to your visit. This completed form will be an important part of your medical record. Each time you return, you should inform your doctor of any changes in your health status and of any changes in your medications. Thank you.

Patient Name: Last_____ First_____ Middle Initial_____

Date of Birth: _____ Age: _____ Date of Appointment: _____

Referring Physician: _____ Primary Care Physician: _____

Breast History:

Reason for your visit? _____

Do you have a breast lump you can feel? _____ If yes, how long has it been there? _____

Where is it? _____ Does it change with menses? _____

Describe any nipple drainage in the past. _____

Do you practice breast self exam? _____ If yes, how often? _____

Age when first menstrual period began? _____ Age of menopause? _____

How many children do you have? _____ Your age when first child was born? _____

How long did you breastfeed, if at all? _____ Could you be pregnant? _____

Have you ever taken oral contraceptives? _____ If yes, how long? _____

Have you had a hysterectomy? _____ If so, was it vaginal or abdominal? (Circle)

Do you still have your ovaries? _____ If not, when were they removed? _____

What types of hormonal therapy have you had and for how long? _____

Date & doctor of last breast exam? _____ Date & doctor of last pelvic exam? _____

Date of most recent mammogram? _____ Where? _____

What previous biopsies, surgeries, or procedures of the breast have you had? Have you had breast cancer?

_____

Please describe any relatives who have had breast cancer (Relationship, age at diagnosis, Current status)

_____

Past Medical History:

Please list any medication allergies: _____
Are you allergic to LATEX? _____

List all current medications (remember to include aspirin, blood thinners, steroids, hormones, etc)

Name Dose How Often?

_____

_____

_____

_____

_____

_____

Do you have any of the following medical conditions? (If needed, explain in detail in "Remarks" area.)

Diabetes	Yes	No	Anesthesia problems	Yes	No
High blood pressure	Yes	No	Bleeding problems	Yes	No
High cholesterol	Yes	No	Arthritis	Yes	No
High lipids	Yes	No	Mental illness	Yes	No
Heart disease	Yes	No	Alcoholism	Yes	No
Heart attack	Yes	No	AIDS/HIV	Yes	No
Atrial fibrillation	Yes	No	Obesity	Yes	No
Pulmonary embolism	Yes	No	Osteoporosis	Yes	No
Pacemaker	Yes	No	Endometrial cancer	Yes	No
Automatic defibrillator	Yes	No	Ovarian cancer	Yes	No
Coumadin therapy	Yes	No	Lung cancer	Yes	No
Emphysema/Asthma	Yes	No	Colon cancer	Yes	No
Stroke	Yes	No	Skin cancer/Melanoma	Yes	No
Kidney disease	Yes	No	Breast cancer	Yes	No
Thyroid disease	Yes	No	Other cancer	Yes	No
Seizure disorder	Yes	No	Other illness	Yes	No

Remarks:_____
_____
_____

Past Medical History, continued:

Please list prior surgeries:

_____
_____
_____
_____
_____
_____

Have you ever had a colonoscopy? _____If yes, how recently? _____

Social History:

Have you used any of the following substances?

Alcohol	Yes	No	If yes, how often? _____	
Cigarettes	Yes	No	If yes, how many packs per day? _____	How many years? _____
Did you stop smoking?	Yes	No	If yes, when? _____	
Other tobacco	Yes	No	If yes, how often? _____	How many years? _____
Illicit drugs	Yes	No	If yes, how often? _____	How many years? _____

Occupation _____

Family History:

Does anyone in your family have any of the following conditions? (If so, list relationship to you.)

Diabetes	Yes	No	Breast cancer	Yes	No
High blood pressure	Yes	No	Ovarian cancer	Yes	No
Heart disease	Yes	No	Colon cancer	Yes	No
Heart attack	Yes	No	Pancreatic cancer	Yes	No
Stroke	Yes	No	Endometrial cancer	Yes	No
Bleeding problems	Yes	No	Lung cancer	Yes	No
BRCA gene mutation	Yes	No	Prostate cancer	Yes	No
Anesthesia problems	Yes	No	Melanoma	Yes	No

Remarks:_____
_____
_____

Review of Systems:
Circle all responses that apply to you.

Constitutional: Fatigue Fevers Weight loss Weight gain Night sweats

Eyes: Corrective lenses Blindness Glaucoma Retinal problems

Ear, Nose &Throat: Hearing loss Nose bleeds Voice change Sinusitis

Respiratory: Shortness of breath Tuberculosis Bloody cough Pneumonia Chronic cough

Cardiovascular: Calf pain when walking Irregular heart beat Swelling of feet Murmur
Deep venous thrombosis Rapid heart beat Congestive heart failure

Gastrointestinal: Gallbladder problems Liver problems Colitis Ulcers Pancreatitis Jaundice
Constipation Diarrhea Blood in stool Swallowing problems

GU/GYN: Abnormal Pap smear Abnormal vaginal bleeding Kidney stones
Painful urination Urinary incontinence Bloody urine

Musculoskeletal: Osteoporosis Artificial joints Chronic back pain Bone pain

Skin: Varicose veins Unusual skin lesions Psoriasis Eczema Melanoma

Neurological: Migraines Paralysis Head injury Memory loss Seizures

Psychiatric: Depression Mood swings Anxiety

Endocrine: Heat intolerance Cold intolerance Thyroid problems

Heme/Lymph: Easy bruising Blood transfusions Enlarged lymph nodes Anemia

Allergy/Immune: Prior immunotherapy or interferon Seasonal allergies Food allergies

Oncology: Chemotherapy Radiation therapy

Remarks:_____

_____

_____

Patient Signature: _____ **Date: _____**

Physician Signature: _____ **Date: _____**

Have you ever been a patient of our providers? Yes No