



Today's Date _____

Patient _____ DOB _____

Please complete ENTIRE form. Mark "N/A" for areas that do not pertain to you

Internist/Family Doctor _____

OB/Gynecologist _____

Chief Complaint/Concerns _____

First Noticed _____ Severity or size _____

Possible Causes (stress, medications, menstrual cycle) _____

Medication Allergies

Reaction

Current Medications

Dosage

Frequency

Medical Conditions/Past Surgical History – Please CHECK all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> TB |
| <input type="checkbox"/> Depression or Anxiety | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |

Cancer (Ovarian, Thyroid, Skin) – What type? _____

Procedure

Condition

Year

Age Menstrual Cycle Began _____ Date of Last Menstrual Period _____ Menopause Age _____

Age at delivery of first live child _____ Pregnancies (How many?) _____ Number of Children _____ Boys _____ Girls _____

Are you taking hormones? _____ Have you in the past? _____ What kind? _____ Date Stopped _____

Social History

Do you currently use or have you used tobacco products? _____ Packs daily? _____ How long? _____
Do you drink caffeine? _____ Servings per day: Coffee _____ Tea _____ Cola _____
Do you drink alcohol? _____ Type _____ How often? _____
Is there any history of illegal drug use? _____ ****This information is strictly confidential and is for medical purposes only****

Family History of Breast Cancer

Please list approximate age of diagnosis.

First Degree Relatives: Self _____ Mother _____ Sister(s) _____ Daughter(s) _____
Maternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Other _____ Men _____
Paternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Other _____ Men _____

Family History

Has anyone in your family had any of the following? Please indicate which family member.

Diabetes _____ High Blood Pressure _____
Heart Attack _____ Illness that "runs" in the family _____
Heart Failure _____ Stroke _____
Cancer – What type? _____

Review of Systems

Have you had any of the following? Please CHECK all that apply.

Breast: [] Discharge [] Pain [] Lumps [] Nipple Inversion
Cardiovascular: [] Shortness of Breath When Lying Flat [] Heart Attack Like Chest Pain [] Swelling in Feet
Endocrine: [] Excessive Thirst [] Excessive Urination [] Feeling Too Hot [] Feeling Too Cold
Gastrointestinal: [] Indigestion [] Vomiting [] Diarrhea [] Blood in Stool [] Constipation
Lymphatic: [] Swelling in Glands
Musculoskeletal: [] Back Trouble [] Arthritis [] Pain
Neurological: [] Blindness [] Fainting [] Weakness on One Side [] Seizures
Psychiatric: [] Depression [] Anxiety [] Suicidal Thoughts
Respiratory: [] Smothering [] Waking Up Short of Breath [] Persistent Cough
Skin Trouble: [] Please explain _____
Urinary: [] Trouble Passing Urine [] Frequency [] Urgency [] Pain