General Information

Patient Name: ____ Date of Birth: ___________________________

Age: _________________ Sex: Female Male Race: _________________________________

Reason for today's visit? ____

Pharmacy and location: ____

Medications and Dosages

Please list ALL prescription and over-the-counter medications.

1: ____________________________ 2: ____________________________ 3: ____________________________

4: ____________________________ 5: ____________________________ 6: ____________________________

7: ____________________________ 8: ____________________________ 9: ____________________________

10: ___________________________ 11: ___________________________ 12: ___________________________

Allergies

1: ____________________________ 2: ____________________________ 3: ____________________________

4: ____________________________ 5: ____________________________ 6: ____________________________

7: ____________________________ 8: ____________________________ 9: ____________________________

Operations/Hospitalizations (please provide approximate dates)

____ ____

____ ____

____ ____

____ ____

____ ____

Have you had a colonoscopy? If yes, When? ____________________ Where? _____________________________

Have you had cancer? If yes, Type? ____

Your Past Medical History (Please circle all that apply to you)

Angina	Asthma	Arthritis	Atrial Fibrillation	Blood Clots
Diabetes	Emphysema	Fibromyalgia	Glaucoma	Heart Attack
Heart Murmur	High Blood Pressure	High Cholesterol	Mood Disorders	Thyroid Disorders
Stroke/TIA	COPD	Congestive Heart Failure	Coronary Artery Disease	

Other: ____

Do you see a heart doctor? If yes, who? ____

Date last seen? __________________________________ Last stress test? ___________________________

Social History (please circle or fill in the blank)

Employed? Full Time Part Time
Unemployed
Disabled
Student
Retired
Housewife

Alcohol Use? YES NO
Number of drinks? _____________
How often? Day Week Month

Smoker? YES NO
Number per day? ________
Years smoked? __________

Former Smoker? YES NO
Date Quit? ______________

Smokeless tobacco? YES NO
Use of illegal drugs? YES NO
Type? _______________________
How often? __________________

Marital Status?
Married
Single
Widowed
Separated
Divorced
Life Partner

Number of children
____

Family History

***Please provide medical history for: mother/father, brother/sister, grandmother/grandfather, aunt/uncle. Also indicate maternal (mother's side) or paternal (father's side)**

Aortic Aneurysm: ____________________________ Bleeding Disorder: ___________________________

Cancer: (please list type & age of onset) ____

____

Diabetes: __________________________________ Heart Attack: ________________________________

High Blood Pressure: _________________________ Stroke/TIA: _________________________________

Other: ____

Have you had a breast biopsy or breast surgery in the past? (If so, please mark below) YES NO

Procedure	Left	Right	Year	Result
Stereo Biopsy				
Mastectomy				
Lumpectomy/Biopsy				
Needle Aspiration				
Implants				
Reduction				

Are you having any problems with either breast **TODAY**? (If yes, please circle below) YES NO

Lump	Left	Right	Nipple Discharge	Left	Right
Pain	Left	Right	Nipple Inversion	Left	Right
Ittiration/Redness	Left	Right	Other: __________________	Left	Right

Hysterectomy: YES NO Menopause: YES NO Date of last monthly period: ___________________

Age at first menstrual cycle:______________ Age at first child's birth:_______________

Last mammogram date: _____________________ Last mammogram location? _________________________

Are you currently or were you previously taking female hormones or birth control? YES NO

Type: ____ Age started: ________ Age stopped: __________

Do you have a known BRCA1 or BRCA2 gene mutation? Yes No

Do you have a parent, brother, sister, or child with the BRCA1 or BRCA2 gene mutation? (if so, please list) ____ Yes No

Do you have a personal history of breast and/or ovarian cancer? Yes No

Do you have a family history of breast, ovarian, or pancreatic cancer? (if so, please list the relationship to you and the type of cancer) ____ Yes No

Do you have atypical ductal hyperplasia, atypical lobular hyperplasia, ductal carcinoma in situ, or lobular cancer in situ? (if so, please list) ____ Yes No

Did you have radiation to your chest between the ages of 10-30? Yes No

Do you have Li-Fraumeno, Cowden Syndrome, or Hereditary Diffuse Gastric Cancer? (if so, please list) ____ Yes No

Do you have a first degree relative with any of these symptoms? (if so, please list) Yes No

____

EENMT

Dry eyes	Y	N
Glasses	Y	N
Vision Loss	Y	N
Gum bleeding	Y	N
Hearing loss	Y	N
Nosebleeds	Y	N

General

Change in appetite	Y	N
Fever	Y	N
Night sweats	Y	N
Weight gain	Y	N
Weight loss	Y	N

Breast

Lumps	Y	N
Nipple discharge	Y	N
Swelling	Y	N
Tenderness	Y	N
Fibrocystic changes	Y	N

Cardiovascular

Chest pain at rest	Y	N
Chest pain with activity	Y	N
Chest palpitations	Y	N
Heart murmur	Y	N
Pacemaker	Y	N

Respiratory

Blood in sputum	Y	N
Cough	Y	N
CPAP	Y	N
Home oxygen	Y	N
Shortness of breath at rest	Y	N
Sleep apnea	Y	N
Wheezing	Y	N
COPD	Y	N

Endocrine

Fatigue	Y	N
Heat or cold intolerance	Y	N
Increased thirst	Y	N

Gastrointestinal

Abdominal pain	Y	N
Constipation	Y	N
Dark Stools	Y	N
Diarrhea	Y	N
Difficulty swallowing	Y	N
Gallbladder disease	Y	N
Gallstones	Y	N
Hemorrhoids	Y	N
Nausea/vomiting	Y	N
Rectal bleeding	Y	N

Genitourinary/Nephrology

Burning with urination	Y	N
Dark colored/blood in urine	Y	N
Difficulty voiding	Y	N
History of kidney stones	Y	N
Loss of bladder control/incontinence	Y	N

Genitourinary (Females)

Heavy bleeding with periods	Y	N
Irregular menses	Y	N
Irregular pap smears	Y	N
Irregular vaginal discharge	Y	N

Musculoskeletal

Decreased range of motion	Y	N
Joint swelling	Y	N
Muscle weakness	Y	N
Pain in arms, legs, or back	Y	N

Skin/Dermatologic

Excessive dryness	Y	N
Hair loss	Y	N
Itching	Y	N
Nail Changes	Y	N
Rash	Y	N
Wounds	Y	N

Neurological/Psychiatric

Anxiety	Y	N
Depression	Y	N
Difficulty with memory or speech	Y	N
Dizziness	Y	N
Headaches	Y	N
Seizures	Y	N

Hematological/Lymphatic

Deep vein clot	Y	N
Easy bruising	Y	N
Enlarged lymph nodes	Y	N
Excessive bleeding	Y	N
Transfusions	Y	N

Infectious Disease

MRSA	Y	N
TB	Y	N
Hep B	Y	N
Hep C	Y	N
HIV	Y	N