

# Medical History



Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Referred by Dr. \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

List Current Medications and Dosages: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ (if yes, number of weeks): \_\_\_\_\_

Have you ever had any of the following diseases or medical problems? Please check box if **yes**.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal bleeding              | <input type="checkbox"/> Hay Fever                   | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Alcohol/Drug Abuse             | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Psychiatric Problems    |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Atrial Fibrillation            | <input type="checkbox"/> Herpes/Fever Blisters       | <input type="checkbox"/> Shingles                |
| <input type="checkbox"/> Cancer/Chemotherapy            | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Sickle Cell Disease     |
| <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Hospitalized for any Reason | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Kidney Problems             | <input type="checkbox"/> Tuberculosis (TB)       |
| <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Liver Diseases              | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Frequent Headaches             | <input type="checkbox"/> Lupis                       | _____  |
| <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Mitral Valve Prolapse       | _____  |

Are you allergic to any of the following?

- |                                  |                                       |  |
|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Other Drug Allergies: |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa        | _____  |
| <input type="checkbox"/> Latex   | <input type="checkbox"/> Tetracycline | _____  |
|                                  |                                       | _____  |

Reaction you have to drugs you are allergic to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes No How many cigarettes per day? \_\_\_\_\_ Number of years smoking \_\_\_\_\_

Do you drink alcohol? Yes No How much? \_\_\_\_\_

What surgeries/operations have you had? \_\_\_\_\_

\_\_\_\_\_

**Constitutional Symptoms**

- Fever
- Weight Loss
- Fatigue
- Night Sweats
- Ear/Nose/Mouth /Throat
- Hearing Loss
- Dizziness
- Nose Bleeding
- Chronic Sinus Problems

**Musculoskeletal**

- Joint Pains
- Back Pain
- Cold Extremities
- Joint Replacements

**Gastrointestinal**

- Loss of Appetite
- Change in Bowel Movements
- Frequent Diarrhea
- Constipation
- Blood in Stool
- Abdominal Pain/Heartburn
- Ulcer

**Respiratory**

- Chronic Frequent Cough
- Asthma
- Shortness of Breath
- Spitting up Blood
- COPD

**Endocrine**

- Diabetes
- Thyroid Disease
- Glandular or Hormone Problem

**Cardiovascular**

- Heart Attack
- Chest Pain or Angina
- Palpitations/ Arrhythmia
- Shortness of Breath
- Swelling of Ankles or Hands
- Heart Murmur
- Mitral Valve Prolapse

**Hematologic/Lymphatic**

- Easy Bruising
- Anemia
- Phlebitis
- Enlarged Glands
- Past Transfusions

**Eyes**

- Wear glasses/contacts
- Glaucoma
- Double Vision

**Psychiatric**

- Anxiety
- Depression
- Insomnia
- Memory Loss
- Other \_\_\_\_\_

**Neurological**

- Numbness or Tingling
- Seizures
- Dizziness
- Stroke

**Integumentary (Skin)**

- Rash or Itching
- Change in Skin Color
- Varicose Veins

**Family History:**

Do you have a family history of breast cancer? Yes No

If yes, who?

- |  |  |
|--|--|
| <input type="checkbox"/> Mother _____age diagnosed   | <input type="checkbox"/> Grandmother <input type="checkbox"/> maternal <input type="checkbox"/> paternal _____age diagnosed  |
| <input type="checkbox"/> Father _____age diagnosed   | <input type="checkbox"/> Grandfather <input type="checkbox"/> maternal <input type="checkbox"/> paternal _____age diagnosed  |
| <input type="checkbox"/> Sister _____age diagnosed   | <input type="checkbox"/> Aunt <input type="checkbox"/> maternal <input type="checkbox"/> paternal _____age diagnosed         |
| <input type="checkbox"/> Brother _____age diagnosed  | <input type="checkbox"/> Uncle <input type="checkbox"/> maternal <input type="checkbox"/> paternal _____age diagnosed        |
| <input type="checkbox"/> Daughter _____age diagnosed | <input type="checkbox"/> First cousin <input type="checkbox"/> maternal <input type="checkbox"/> paternal _____age diagnosed |
| <input type="checkbox"/> Son _____age diagnosed      |  |

Do you have a family history of ovarian cancer?  Yes  No

If yes, which relative and age at diagnosis: \_\_\_\_\_

Do you have a family history of colon cancer?  Yes  No

If yes, which relative and age at diagnosis: \_\_\_\_\_

Do you have a family history of prostate cancer?  Yes  No

If yes, which relative and age at diagnosis: \_\_\_\_\_

Other family cancer history: \_\_\_\_\_

Are you of Ashkenazi Jewish Heritage?  Yes  No  Unknown

I certify that the information that I have provided is accurate.

\_\_\_\_\_  
Patient Signature

Physician Review \_\_\_\_\_  
initials

**Reason for Office Visit:**

Do you have a breast lump?  Yes  No  
If yes, which breast?  Right  Left  
If yes, how was it found?  By you  Your physician  Mammogram  Ultrasound  MRI  
 Other (explain): \_\_\_\_\_

Do you have breast pain?  Yes  No  
If yes, which breast?  Right  Left  Both  
If yes, is it worse with your menstrual cycle?  Yes  No relation

Duration of the pain: \_\_\_\_\_

Do you have a breast infection?  Yes  No  
If yes, when did it start? \_\_\_\_\_  
If yes, are you currently taking an antibiotic?  Yes  No Antibiotic: \_\_\_\_\_ Start Date: \_\_\_\_\_  
Are you breastfeeding?  Yes  No

Do you have an abnormal mammogram/ultrasound/MRI?  Yes  No  
Date of last mammogram: \_\_\_\_\_ Location: \_\_\_\_\_  
Date of last ultrasound: \_\_\_\_\_ Location: \_\_\_\_\_  
Date of MRI: \_\_\_\_\_ Location: \_\_\_\_\_  
Date of most recent breast biopsy, nonsurgical: \_\_\_\_\_ Location: \_\_\_\_\_  
Results of recent breast biopsy, nonsurgical: \_\_\_\_\_

Other breast complaints: \_\_\_\_\_

**Breast History**

Age at onset of menses (period): \_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_ Age at first live birth: \_\_\_\_\_

Did you breastfeed?  Yes  No How long? \_\_\_\_\_

Are you taking oral contraceptives?  Yes  No Duration of use: \_\_\_\_\_

Age at menopause \_\_\_\_\_ years  Surgical menopause  Natural menopause

Are you taking hormone replacement?  Yes  No Duration of use: \_\_\_\_\_

Name of HRT: \_\_\_\_\_ Dose: \_\_\_\_\_

Have you had a prior breast surgery?  Yes  No If yes, date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Results of surgery: \_\_\_\_\_

Have you had a prior breast reduction?  Yes, date: \_\_\_\_\_  No

Have you had a prior breast augmentation?  Yes, date: \_\_\_\_\_  No

If yes,  Saline  Silicone  Under muscle  Over muscle  Not sure

Do you have a personal history of breast cancer?  Yes  No

If yes, which breast? \_\_\_\_\_ Date diagnosed: \_\_\_\_\_

Type of surgery: \_\_\_\_\_ Surgery date: \_\_\_\_\_

Type of reconstruction (if applicable): \_\_\_\_\_

Radiation  Yes  No If yes, Date: \_\_\_\_\_ Location: \_\_\_\_\_

Chemotherapy  Yes  No If yes, Date: \_\_\_\_\_

Oncologist: \_\_\_\_\_

Physician Review \_\_\_\_\_  
initials