Patient History

Name:_____ **Date of Birth:**_____

Current Height:_____ **Current Weight**:_____

CURRENT ISSUE

Please describe the breast issue that brings you to The Breast Center today:

_____

_____

Please describe any breast issues/biopsies/surgeries you have had in the past:

_____

_____

MEDICAL HISTORY

Which of the following are you currently being treated for or have been treated for in the past *(check all that apply)*

☐ Heart disease	☐ Shortness of breath	☐ Eye problems/Glaucoma	☐ Diabetes
☐ High blood pressure	☐ Asthma	☐ Seizures	☐ Kidney/Bladder problems
☐ High Cholesterol	☐ Lung problems	☐ Stroke	☐ Hepatitis/Liver problems
☐ Heart burn (reflux)	☐ Sinus problems	☐ Headaches/Migraines	☐ Arthritis
☐ Anemia	☐ Allergies	☐ Neurological Problems	☐ Thyroid Disease
☐ Swollen Ankles	☐ Ear/nose/throat problems	☐ Depression/Anxiety	☐ Ulcers/Colitis
☐ Cancer: Type?_____			☐ **NONE**

Please describe any current or past medical problem not listed above:

_____

_____

Do you have an Advance Directive? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No If yes, when & what for?_____

Have you had the flu shot? *(Oct 1 – Apr 1)* ☐ Yes ☐ No If yes, when? (approx.)_____

Have you received a pneumonia vaccine? ☐ Yes ☐ No If yes, when? (approx.)_____

Have you ever received radiation therapy? ☐ Yes ☐ No If yes, when & where?_____

Have you ever received chemotherapy? ☐ Yes ☐ No If yes, when & where?_____

Have you ever had surgery? ☐ Yes ☐ No If yes, any reaction to anesthesia? ☐ Yes ☐ No

If yes, please list your past surgeries & approximate date or age you were at the time of surgery

Surgery	**Date/age**	**Surgery**	**Date/age**

Do you have any allergies to medication or food? ☐ Yes ☐ No If yes, please list what & your reaction

Medication/Food	Reaction	Medication/Food	Reaction

MEDICATIONS ☐ **Do not currently take any prescribed or over the counter medications**

Please list all medications you currently take, include over the counter medications such as vitamins.

Name of Medication	Dose	Name of Medication	Dose

GYNECOLOGIC HISTORY

Age at first menstruation:_____ **Number of pregnancies:**_____

Date of last period:_____ **Number of births:**_____

If post-menopausal: Age at menopause_____ **Number of miscarriages:**_____

Your age when you had your first child:_____ **Number of abortions:**_____

Have you taken any of the following?

Birth control pills	☐ Yes	☐ No	If yes, for how long?_____
Estrogen/Hormones	☐ Yes	☐ No	If yes, for how long?_____
Tamoxifen	☐ Yes	☐ No	If yes, for how long?_____
Evista	☐ Yes	☐ No	If yes, for how long?_____

CURRENT MEDICAL CONDITION

Are you *currently* experiencing any of the following? ***(check all that apply)***

☐ Headache	☐ High blood pressure	☐ Diarrhea	☐ Muscle Pain
☐ Dizziness	☐ Chest pain	☐ Blood in stool or black stool	☐ Forgetfulness
☐ Fainting	☐ Shortness of breath	☐ Jaundice	☐ Fatigue
☐ Vision problems	☐ Swelling in your ankles	☐ Kidney problems	☐ Worry
☐ Eye pain	☐ Pain in legs when walking	☐ Pain when urinating	☐ Depression
☐ Cataracts	☐ Heart murmur	☐ Difficulty urinating	☐ Insomnia
☐ Glaucoma	☐ Cough	☐ Frequency when urinating	☐ Painful intercourse
☐ Ear ache	☐ Coughing up blood	☐ Laryngitis	☐ Bleeding after intercourse
☐ Ringing in the ears	☐ Night sweats	☐ Hoarse voice	☐ Painful periods
☐ Difficulty hearing	☐ Asthma	☐ Swollen lymph nodes	☐ Irregular periods
☐ Sinus congestion	☐ Decreased appetite	☐ Sore throat	☐ Vaginal discharge
☐ Nose bleeds	☐ Difficulty swallowing	☐ Arthritis	☐ Vaginal Bleeding
☐ Bleeding gums	☐ Nausea	☐ Bone pain	☐ Other:_____
☐ Skin problems	☐ Vomiting	☐ Difficulty with hand/foot coordination	☐ Other: _____
☐ Hypothyroid	☐ Heartburn		☐ Other: _____
☐ Hyperthyroid	☐ Constipation	☐ Numbness in hands or feet	

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No If yes, age when started:_____Packs per day?_____

Did you smoke in the past? ☐ Yes ☐ No If yes, for how many years:_____Packs per day?_____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how often:
☐ Daily ☐ 1-2 times/week ☐ 1-2 times/month ☐ 1-2 times/year

Did you drink alcohol in the past? ☐ Yes ☐ No If yes, how often:
☐ Daily ☐ 1-2 times/week ☐ 1-2 times/month ☐ 1-2 times/year

Do you currently use illegal drugs or prescription drugs for non-medical reasons? ☐ Yes ☐ No If yes, how often:
☐ Daily ☐ 1-2 times/week ☐ 1-2 times/month ☐ 1-2 times/year

Did you use illegal drugs or prescription drugs for non–medical reasons in the past? ☐ Yes ☐ No If yes, how often:
☐ Daily ☐ 1-2 times/week ☐ 1-2 times/month ☐ 1-2 times/year

Is religion/faith/spirituality important to you? ☐ Yes ☐ No

Do you have concerns about your nutrition? ☐ Yes ☐ No If yes, what?_____

Do you live with: ☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Significant Other?

What is your employment status? ☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed
☐ Other:_____

If you are working what job do you do?_____

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My Adventist Health

You can have access to your results and testing via the patient portal. If you are interested in this please give us your email address. You will receive a welcome email with instructions on how to access the patient portal.

Email address:_____

☐ I wish to decline at this time *(If you change your mind let us know, you can sign up at any time!)*

Family History

Name:_____ **Date of Birth:**_____

Please indicate if there is a family history of any of the following: The following blood relatives should be considered: *Mother, Father, Sister, Brother, Son, Daughter, Grandparents, Aunts, Uncles, First-Cousins, Half-Sibling*

Medical Condition			Which relative *(indicate moms or dads side)*	Age at diagnosis
FAMILY HISTORY: CANCER				
Breast cancer	☐ Yes	☐ No		
Ovarian cancer	☐ Yes	☐ No		
Uterine cancer	☐ Yes	☐ No		
Prostate cancer	☐ Yes	☐ No		
Pancreatic cancer	☐ Yes	☐ No		
Colon cancer	☐ Yes	☐ No		
Brain cancer	☐ Yes	☐ No		
Leukemia	☐ Yes	☐ No		
Lung cancer	☐ Yes	☐ No		
Melanoma	☐ Yes	☐ No		
Skin cancer	☐ Yes	☐ No		
Gastric cancer	☐ Yes	☐ No		
Other cancer:_____	☐ Yes	☐ No		
Other cancer:_____	☐ Yes	☐ No		
Are you & your family of Ashkenazi Jewish ancestry? ☐ Yes ☐ No				
Have you or any member of your family had genetic testing completed? ☐ Yes ☐ No				
FAMILY HISTORY: CARDIOVASCULAR				
Heart Disease	☐ Yes	☐ No		
Heart Failure	☐ Yes	☐ No		
Heart Attack	☐ Yes	☐ No		
High Blood Pressure	☐ Yes	☐ No		
High Cholesterol	☐ Yes	☐ No		
FAMILY HISTORY: ENDOCRINE/METABOLIC				
Cushing's Disease	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Graves Disease	☐ Yes	☐ No		
Thyroid Disease	☐ Yes	☐ No		
FAMILY HISTORY: GASTROINTESTINAL				
Diverticulitis	☐ Yes	☐ No		
Ulcerative colitis	☐ Yes	☐ No		
Crohns Disease	☐ Yes	☐ No		
Gallbladder Disease	☐ Yes	☐ No		
Liver Disease	☐ Yes	☐ No		
Pancreatitis	☐ Yes	☐ No		

Please indicate if there is a family history of any of the following: The following blood relatives should be considered: *Mother, Father, Sister, Brother, Son, Daughter, Grandparents, Aunts, Uncles, First-Cousins, Half-Sibling*

FAMILY HISTORY: GENITOURINARY				
Bladder Disease	☐ Yes	☐ No		
Kidney Disease	☐ Yes	☐ No		
Kidney Failure	☐ Yes	☐ No		
FAMILY HISTORY: HEMATOLOGIC				
Anemia	☐ Yes	☐ No		
Bleeding Disorder	☐ Yes	☐ No		
Clotting Disorder	☐ Yes	☐ No		
Hemophilia	☐ Yes	☐ No		
Sickle Cell	☐ Yes	☐ No		
FAMILY HISTORY: IMMUNOLOGIC				
Autoimmune Disease	☐ Yes	☐ No		
Lupus	☐ Yes	☐ No		
Multiple Sclerosis	☐ Yes	☐ No		
FAMILY HISTORY: MUSCULOSKELETAL				
Arthritis	☐ Yes	☐ No		
Rheumatoid Arthritis	☐ Yes	☐ No		
Fibromyalgia	☐ Yes	☐ No		
Osteoporosis	☐ Yes	☐ No		
FAMILY HISTORY: NEUROLOGIC				
Alzheimer's Disease	☐ Yes	☐ No		
Epilepsy	☐ Yes	☐ No		
Seizure	☐ Yes	☐ No		
Stroke	☐ Yes	☐ No		
FAMILY HISTORY: PSYCHIATRIC				
Anxiety	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
FAMILY HISTORY: RESPIRATORY				
Asthma	☐ Yes	☐ No		
COPD	☐ Yes	☐ No		

Any other family history you would like to tell us about?_____