Personal Medical History

Demographic information

Name: _____

Date of visit: _____ DOB: _____

Breast and Reproductive History

Please describe the reason for the visit today:_____

Do you have annual breast exams by a health practitioner? ☐ Yes ☐ No

Do you perform self breast exams regularly (at least every 2 months)? ☐ Yes ☐ No

Have you or your practitioner found any abnormal lumps? ☐ Yes ☐ No
If yes, please explain: _____

Do you have annual mammogram? ☐ Yes ☐ No
Date of your last mammogram: _____

Have you ever had abnormal mammogram? ☐ Yes ☐ No
If yes, provide date and results: _____

Age of first period: _____ Date of last period: _____ Age at menopause: _____

Age when you had first child: _____ Number of Pregnancies: _____ Number of live births: _____

Did you breast feed? ☐ Yes ☐ No If yes, how long for each child? _____

Have you ever taken birth control pills? ☐ Yes ☐ No If yes, are you currently taking them? ☐ Yes ☐ No

Have you ever taken hormone replacement therapy or fertility drugs? ☐ Yes ☐ No
If yes, list names and duration: _____

Any prior breast needle biopsies? (Please bring results if possible) ☐ Yes ☐ No

List any prior breast surgeries: _____

Have you ever had breast cancer? ☐ Yes ☐ No If yes what type (if known) _____

Have you ever had breast/chest radiation therapy? ☐ Yes ☐ No, Date: _____

Any other information you would like to add: _____

Personal Medical History

Allergies

Do you have any medications allergies? ☐ Yes ☐ No medications allergies.
Please list any medications allergies

Medication Name and Reaction	Medication Name and Reaction

Medications

Please list all current medications that you take including over the counter medications

Name, Dose and Frequency	Name, Dose and Frequency

Review of Systems

Check as applicable:

Constitutional

Fatigue	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No

Head and Neck

Eye discharge	☐ Yes	☐ No
Vision loss	☐ Yes	☐ No
Ear problems	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Dyspnea	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Leg pain	☐ Yes	☐ No
Irregular heart	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No

Genitourinary

Painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No

Metabolic

Cold intolerance	☐ Yes	☐ No
Heat intolerance	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Extreme hunger	☐ Yes	☐ No

Neuro/Psychiatric

Dizziness	☐ Yes	☐ No
Psychiatric symptoms	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Memory impairment	☐ Yes	☐ No

Musculoskletal

Bone/join pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No

Personal Medical History

Review of Systems (cont.)

Check as applicable:

Skin / Breast

Breast pain ☐ Yes ☐ No

Breast discharge ☐ Yes ☐ No

Itching ☐ Yes ☐ No

Rash/ Skin lesions ☐ Yes ☐ No

Hematology/Immunology

Swollen glands ☐ Yes ☐ No

Location: _____

Date of last Mammogram

_____

Bra size: _____

Past Medical History

Please check all applicable. Use the space below for any additional remarks.

- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety/ Depression
- ☐ Asthma/ COPD
- ☐ Atrial Fibrillation
- ☐ Bleeding disorder
- ☐ Blood clots/PE/DVT
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Endocarditis
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Heart attack
- ☐ Heart valve disease
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyper/Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Lupus/Rheumatoid
- ☐ Malignant Hyperthermia
- ☐ Migraine headaches
- ☐ MRSA/VRE
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Anesthesia complications
- ☐ Pulmonary Fibrosis
- ☐ Radiation
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Other
- ☐ Other
- ☐ Other

Past Surgical History

Date	Surgical Procedure

Personal Medical History

Family History

Do you have any family member with any of the following cancers?

☐ Colon Cancer ☐ Pancreatic Cancer ☐ Prostate Cancer ☐ Thyroid Cancer
☐ Uterine Cancer ☐ Melanoma ☐ Sarcoma ☐ Breast Cancer
☐ Ovarian Cancer ☐ Other _____

Family Member	Cancer Type	Age at Diagnosis

What is your ethnic background (for example German)? _____

Do you have Eastern European Jewish Heritage in your family? _____

Social History

Are you currently employed? ☐ Yes ☐ No ☐ Disabled ☐ Unemployed

If yes, What is your occupation? _____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Never married

Use of Alcohol: ☐ Never ☐ Rarely ☐ Socially ☐ Daily Type: _____

Use of Tobacco: ☐ Never ☐ Rarely ☐ Socially ☐ Daily Type: _____

Use of Illicit Drugs:: ☐ Never ☐ Rarely ☐ Socially ☐ Daily Type: _____

Caffeine Intake: ☐ Never ☐ Rarely ☐ Socially ☐ Daily Type: _____

Cups per day: _____