

## 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:

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

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### MEDICAL HISTORY

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

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

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

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

**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?** \_\_\_\_\_



**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 ( <i>indicate moms or dads side</i> )	Age at diagnosis
<b>FAMILY HISTORY: CANCER</b>				
Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Ovarian cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Uterine cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Prostate cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pancreatic cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Colon cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Brain cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Lung cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Gastric cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other cancer: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other cancer: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you & your family of Ashkenazi Jewish ancestry? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you or any member of your family had genetic testing completed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>FAMILY HISTORY: CARDIOVASCULAR</b>				
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<b>FAMILY HISTORY: ENDOCRINE/METABOLIC</b>				
Cushing's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Graves Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<b>FAMILY HISTORY: GASTROINTESTINAL</b>				
Diverticulitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Ulcerative colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Crohns Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Gallbladder Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: HEMATOLOGIC			
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Clotting Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sickle Cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: IMMUNOLOGIC			
Autoimmune Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: MUSCULOSKELETAL			
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: NEUROLOGIC			
Alzheimer's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: PSYCHIATRIC			
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
FAMILY HISTORY: RESPIRATORY			
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_