PATIENT LABEL:

SURGICAL
ASSOCIATES
Center for Breast Care

Date ____________________

New Patient _____

Return Patient (Revision) _____

WHY ARE YOU HERE TODAY? ____________________

WHO REFERRED YOU TO SURGICAL ASSOCIATES CENTER FOR BREAST CARE? ____________________

WHO IS YOUR PRIMARY CARE DOCTOR? ____________________

WHO IS YOUR GYNECOLOGIST? ____________________

WHAT OTHER PHYSICIAN DO YOU SEE? ____________________

WHICH OF THE FOLLOWING DO YOU NOW HAVE OR HAVE HAD IN THE PAST:

Breast lump ____

Breast pain ____

Nipple discharge____

If yes please describe ____________________

Previous biopsy ____

If yes what was found ____________________

____

Previous cyst aspiration ____

Previous abnormal mammogram ____

When and where was your last mammogram ________

____

Change in size of breast(s) ____

Previous breast surgery ____

Cancer ____ ☐ Breast ☐ Ovarian ☐ Colon

Plastic surgery ____

Your age at first menstrual period ____

Last menstrual period (date or age) ____

Number of pregnancies ____

Number of live births ____

Number of abortions or miscarriages ____

Age at first pregnancy ____

Was this a full term pregnancy, miscarriage or abortion?

____

Have you taken birth control pills? ____

If so, at what age did you start these and how long have you taken them. ____________________

Do you take replacement hormone therapy? ____

If so, what do you take and how long have you taken this. ____________________

____

Have you had a hysterectomy? ____

If so, why and were your ovaries removed? ________

____

Did you breast feed your children? ____

If so, how long ____________________

Have you had a bone density scan for osteoporosis?

When? ____________________

FAMILY HISTORY:

Give us as extensive a history of family diseases as possible, particularly any history of breast, colon,and ovarian cancers. If there is a strong history of these cancers, we would like to have you provide a very extensive history of cancer in your family and a separate paper will be provided for this. If they have had cancer, please tell us at what age.

Maternal Grand Mother ______________________________

Maternal Grand Father ______________________________

Paternal Grand Father ______________________________

Paternal Grand Mother ______________________________

Mother ______________________________

Father ______________________________

Brothers ______________________________

Sisters ______________________________

Children ______________________________

Cousins ______________________________

Aunts ______________________________

Uncles ______________________________

Others ______________________________

Ashkenazi Jewish descent? ______

Have members of your family or you had:

Unusual reaction to anesthetic ______________________________

Bleeding disorder ______________________________

Genetic disorders ______________________________

REVIEW OF SYSTEMS: (Please Circle if you have or have had any of the following)

Constitutional:
Change in weight
Unusual fatigue
Fever or night sweats

Eyes:
Glasses or contact lenses
Cataracts (if yes, surgery?)
Loss of vision
Double vision

Ears, Nose, and Throat:
Hearing problem
Ringing in ears
Hearing aids
Nose Bleeds
Sinus or Allergy problems
Hoarseness or voice change
Dentures or dental problems

Gastrointestinal:
Difficulty swallowing
Ulcers
Hiatal Hernia/ Esophageal reflux
Jaundice or Hepatitis
Change in bowel habits
Food intolerances
Bleeding (vomiting or stool)
Hemorrhoids or rectal problems

Skin:
Rashes
Hair loss
Skin cancers

Endocrine:
Thyroid problems
Diabetes
Adrenal or Parathyroid problems

Genitourinary:
Urinary tract infections
Kidney stones
Blood in the urine
Difficulty urinating
Urine Control Problems
Abnormal Vaginal bleeding
Abnormal Discharge
Painful intercourse
Previous Herpes, HIV, AIDS, Syphilis, gonorrhea, or venereal warts

Hematologic/Lymphatic:
Anemia (if yes, when and what type)
Bleeding disorder
Blood transfusions (if yes, when, why, and how many)
Do you use blood thinners
Spleen disorder
Lymph node enlargement or surgery

REVIEW OF SYSTEMS: (Please Circle if you have or have had any of the following)

Cardiovascular:
Heart disease
Heart attack
Chest pain
Heart surgery
Heart murmur
Irregular heart beat or palpitations
Blood clots/ phlebitis
High blood pressure
Congestive heart failure

Pulmonary:
Persistent cough
Asthma,wheezing
Pneumonia
Shortness of breath
Emphysema or chronic bronchitis

Musculoskeletal:
Broken Bones
Arthritis
Osteoporosis
Back or Neck Pain
Disc disease
Loss of height

Neurologic:
Headaches, Migraines
Head injury, unconsciousness
Weakness in arms or legs
Convulsions (seizures)
Stroke

Allergy/Immunology:
Serious allergies
Allergy to what: ______________________
Serious infections

Immunizations:
Childhood illnesses (measles, mumps, whooping cough, chickenpox)
Cortisone therapy

Psychiatric:
Depression
Anxiety
Psychiatry care
Difficulty with thinking or memory

PLEASE LIST ALL HOSPITALIZATIONS AND SURGERY WITH DATES, PHYSICIAN AND REASON FOR HOSPITALIZATION OR SURGERY:

PROCEDURE/HOSPITALIZATION	WHERE/WHEN	DOCTOR	PROBLEM

MEDICATIONS (Please list all medications, both prescription and over the counter and dose of each. Also vitamins and other non prescription items.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE	MEDICATION	DOSAGE

DRUG ALLERGIES: Name drug and type of reaction

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____

____

LATEX ALLERGY: ____

PLEASE LIST PRESENT ILLNESS (DIABETES, HYPERTENSION)

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ADDITIONAL SPACE IF NEEDED FOR COMMENTS, MORE MEDICAL HISTORY OR MORE INFORMATION.

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SOCIAL HISTORY:

MARITAL STATUS ______________________

OCCUPATION ______________________ (IF RETIRED WHAT DID YOU DO) ______

____

DISABLED? _______

HABITS:

SMOKING: NO _____ YES _____ IF YES, HOW MUCH _____ HOW MANY YEARS _____

ALCOHOL: NO _____ YES _____ IF YES, HOW MUCH PER DAY OR WEEK AND WHAT TYPE OF ALCOHOL _____

____

DRUGS:

MARIJUANA _____ COCAINE _____ METHAMPHETAMINES _____ OTHER ______________________

HAVE YOU BEEN IN REHABILITATION FOR DRUGS OR ALCOHOL? ______

TO BE FILLED BY MEDICAL PERSONNEL **BP** ______________ **P** _______ **T** _______

DOCTOR'S SIGNATURE: ______________________________ DATE: ____________

MEDICAL ASSISTANT: ______________________________ DATE: ____________