

PLEASE PRINT NEATLY!

Date: _____

Chart# _____

Patient Name: _____ Date of Birth: _____ Age: _____ Male / Female

Reason for Today's Visit: _____

Please check (✓) any of the following ALLERGIES that apply to YOU:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Latex	<input type="checkbox"/> None
<input type="checkbox"/> Other (Please explain)					

List all MEDICATIONS: (Include OTC & Herbs)	Dose:	Reason for use:

Do you take:	YES	NO	Explain:
Aspirin	_____	_____	_____
Blood Thinners	_____	_____	_____
Steroids	_____	_____	_____
Hormones	_____	_____	_____

Last Mammogram- _____
 Where- _____
 Last Ultrasound- _____
 Where- _____
 Date of Last Menstrual Cycle _____

List all surgeries, breast procedures and hospitalizations:

Procedure	Date	Where/Doctor

Please list other physicians you see:

Primary Care _____
 OB/GYN _____
 Med Oncologist _____
 Rad Oncologist _____
 Cardiologist _____
 Neurologist _____
 Other _____

Reproduction (For Women):

Age at onset of menstruation:		Have you had:	YES	NO
Age at first pregnancy		-a hysterectomy		
Number of pregnancies		-your ovaries removed		
Number of live births		Are you in menopause?		

Family History of Breast Cancer: Self Mother
 Sister(s) # _____ Daughter None
 Maternal- Grandmother Aunt Cousin
 Paternal- Grandmother Aunt Cousin

Past Medical History: Please check (✓) any of the following conditions that apply to YOU

<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Other: _____		

Review of Symptoms: Please check (✓) any of the following conditions that you are currently experiencing

✓ Head & Neck:	✓ Heart & Lungs:	✓ Gastrointestinal:	✓ Musculo-Skeletal:	✓ Endocrine:
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Heartburn/Reflux	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Bone Pain	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Dark or Bloody Stools	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Thyroid Medications
<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Thyroid Surgery
<input type="checkbox"/> Earaches	<input type="checkbox"/> Rapid Heartbeat		<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Temp Intolerance
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Leg Cramps	Psychiatric:	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Loss of Limb	Genitourinary:
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Drug/Alcohol Abuse		<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Change in Voice	Neurological:		Gynecology:	<input type="checkbox"/> Kidney infection
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Headaches	Heme/Lymph:	<input type="checkbox"/> Uterine Polyps	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Skin:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anemia	<input type="checkbox"/> Abn Vaginal Bleeding	<input type="checkbox"/> Slow start of urine
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Migraines	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Abn Pap Smea	<input type="checkbox"/> Bladder Infection
<input type="checkbox"/> Previous Biopsies	<input type="checkbox"/> Slurred Speech	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Weakness Side	<input type="checkbox"/> Easy Bruising		

OFFICE USE ONLY:

I have reviewed this document with the patient.

Physician Signature _____ Date _____