Birmingham Breast Care
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MEDICAL HISTORY

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:

	Z-pac		Cipro		Codeine		Keflex		Latex		Levaquin		Lortab		NSAIDs		Peanuts						
	Penicillin		Aspirin		Sulfa		Tetracycline		Ultram														
	Other*(Please explain)*																						

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

List all surgeries, breast procedures and hospitalizations:

Procedure	Date	Where/Doctor

How many caffeinated drinks do you consume daily?		Have you had:	YES	NO
Do you have metal anywhere in your body? If so, where? _____		-a hysterectomy		
Do you perform monthly self breast exams?		-your ovaries removed		
Age at onset of menstruation:		Are you in menopause?		
Age at first pregnancy		Have you had a breast reduction/mammoplasty?		
Number of pregnancies		Do you have breast implants?		
Number of live births		Do you smoke?		
How long did you nurse?		Do you consume alcohol on a regular basis?		
What is your bra cup size? (a letter)		Do you take hormones? If so, what?_____		

Please list any physicians you see:

Primary Care_____
OB/GYN_____
Plastic Surgeon_____
OB/GYN_____
Med Oncologist_____
Rad Oncologist_____
Cardiologist_____
Neurologist_____
Other_____

Family History of Breast Cancer:❑Self ❑Mother ❑Sister(s) #___ ❑Daughter ❑None
Maternal–❑Grandmother ❑Aunt ❑Cousin
Paternal–❑Grandmother ❑Aunt ❑Cousin (Z803)

Family History of Ovarian Cancer:❑Self ❑Mother ❑Sister(s) #___ ❑Daughter ❑None
Maternal–❑Grandmother ❑Aunt ❑Cousin
Paternal–❑Grandmother ❑Aunt ❑Cousin (Z808)

HISTORY:	Alive	Age	Cancer
Mom	☐No☐Yes		☐No☐Yes
Dad	☐No☐Yes		☐No☐Yes
Mat Gmother	☐No☐Yes		☐No☐Yes
Mat Gfather	☐No☐Yes		☐No☐Yes
Pat Gmother	☐No☐Yes		☐No☐Yes
Pat Gfather	☐No☐Yes		☐No☐Yes
Mat Aunt	☐No☐Yes		☐No☐Yes
Pat Aunt	☐No☐Yes		☐No☐Yes
Daughter	☐No☐Yes		☐No☐Yes

Over the last 2 weeks, have you had the following:
1. Little interest or pleasure in doing things: ❑Yes ❑No
2. Feeling down, depressed or hopeless: ❑Yes ❑No

Do you have a personal history of any of the following conditions?

☐Diabetes-Type I (E108) ☐Diabetes-Type II (E1169) ☐Heart Disease (I259) ☐CABG (Z951) ☐High Blood Pressure (I10)

☐High Cholesterol (E780) ☐TIA (Z8673) ☐Stroke (Z8673) ☐HIV (B20) ☐Hepatitis (K759) _____

☐ Reflux (K219) ☐Asthma (J45909) ☐ Emphysema (J439) ☐COPD (J449) ☐Renal Failure (N19) ☐Anemia(D649)

☐ Sleep Apnea (G4730) ☐Narcolepsy (G47419) ☐Dysautonomia (G909) ☐Mitral Valve Prolapse (I348) ☐Fibromyalgia (M797)

☐Thyroid Disorder (E079) ☐Arthritis (M129) ☐Osteoarthritis (M150) ☐Rheumatoid Arthritis (M069)

Please list in detail any other medical conditions: 1. _____;

2. _____; 3._____;

4. _____; 5._____;

PLEASE CONTINUE ON OPPOSITE SIDE OF PAPER

Review of Symptoms: Please check (✓) any of conditions below that you are currently experiencing. Otherwise check → ❍None

Constitutional:	Cardiovascular:	MusculoSkeletal:	Skin:	Hematologic:
❍ Decline in Health R5381	❍ Chest pains R079	❍ Arthritis M129	❍ Hives L500	❍ Anemia D649
❍ Fatigue R538	❍ Palpitations R002	❍ Joint Pain M2550	❍ Rashes R21	❍ Bleeding Easily D689
❍ Fever R509	❍ Heart Murmur R011	❍ Gout M109	❍ Skin Color Change R238	❍ Blood Clots I8291
❍ Weakness R531	❍ History/Heart Attack I252	❍ Deformities	Neurological:	❍ Swollen Glands R599
❍ Weight Gain R635	❍ High Blood Pressure I10	❍ Paralysis G839	❍ Dizziness R42	Endocrine:
❍ Weight Loss R634	Gastrointestinal:	❍ Restricted Motion M2560	❍ Fainting R55	❍ Goiter E049
Respiratory:	❍ Abdominal Pain R1084	Psychiatric:	❍ Head Injury	❍ Thyroid Trouble
❍ Asthma J45909	❍ Constipation K590	❍ Depression F329	❍ Memory Loss R413	Allergic/Immunologic:
❍ Coughing Blood R042	❍ Diarrhea R197	❍ Disorientation F410	❍ Paralysis G839	❍ Coughing R05
❍ Shortness of Breath R0602	❍ Heartburn R12	❍ Hallucinations R443	❍ Speech Disorders F809	❍ Recurrent Infections J309
❍ Bronchitis J209	❍ Rectal Bleeding	❍ Psychiatric Disorders Z8659	❍ Stroke(s) Z8673	❍ Watery Eyes H04209

FOR CANCER PATIENTS:

Did you have chemotherapy? YES or NO What date did you complete chemo?_____

What chemotherapy agents/drugs were administered?_____

Did you have radiation therapy? YES or NO What date did you complete rad tx?_____

How many radiation treatments did you have?_____

What residual effects do you have from either chemotherapy or radiation therapy?_____

As your treating physician it is imperative that we know all medications you are taking and know of all medical conditions you have. Without this accurate information we cannot be held accountable for any drug interactions that may occur.

I hereby certify that my medical and history information I have given is complete and accurate.

_____
Patient Signature

FOR OFFICE USE ONLY: Flu:_____ Colo:_____ CA:___

H_____ W_____ B/P_____ T/C Score:_____

LOC_____ TIM_____

QUA_____ CON_____

SEV_____ M/F_____

DUR_____ A/S_____

SIDE_____PAIN_____ D/C_____ PALP_____ RED_____ FEVER_____ SWELL_____

IMG_____