Birmingham Breast Care
800 St. Vincent's Drive ♦ North Tower Suite 640
Birmingham, AL 35205
(205) 930-0806 ♦ (205) 930-0906 – FAX

MEDICAL HISTORY

Date:______________

Patient Name:____ Date of Birth:_______________ Age:_________ Male / Female

Reason for Today's Visit: ____

Please list any CHANGES or NEW information since your last visit:

Medications:____

Allergies:____

Surgeries:____

Family History of Cancer (relationship, type of cancer and age):____

Medical Conditions:____

Physicians:____

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	❍ Psych Disorders Z8659	❍ Stroke(s) Z8673	❍ Watery Eyes H04209

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____