Comprehensive Breast Center – Medical History Form

Name: ____________________________ Date of Birth: ________________

Past Medical History (Please darken bubble completely – indicate only Yes response)					
Acute Myocardial Infarction (Heart Attack)	O Yes	O No	Myocardial Infarction	O Yes	O No
Atrial Fibrillation (Irregular Heartbeat)	O Yes	O No	Multiple Sclerosis	O Yes	O No
Carotid Stenosis (Blockage In Neck)	O Yes	O No	Obesity	O Yes	O No
Cardiomyopathy (Enlarged Heart)	O Yes	O No	Ovarian Mass	O Yes	O No
Asthma	O Yes	O No	Parkinsons Disease	O Yes	O No
Anxiety	O Yes	O No	Renal Insufficiency, Chronic-Kidney	O Yes	O No
Blood Dyscrasias (Blood Clotting Disorder)	O Yes	O No	Rheumatic Heart Disease	O Yes	O No
Cirrhosis	O Yes	O No	Sleep Apnea	O Yes	O No
Diabetes Mellitus	O Yes	O No	Seizures	O Yes	O No
Emphysema	O Yes	O No	Stroke	O Yes	O No
Family History Of Colon Cancer	O Yes	O No	Cancer, Breast	O Yes	O No
Family History Of Coronary Artery Disease	O Yes	O No	Cancer, Colon	O Yes	O No
Heart Murmur (Mitral Valve Prolapse)	O Yes	O No	Cancer, Lung	O Yes	O No
Hypercholesterolemia (High Cholesterol)	O Yes	O No	Cancer, Melanoma	O Yes	O No
Hypertension	O Yes	O No	Cancer, Lymphoma	O Yes	O No
Hepatitis C	O Yes	O No	Cancer, Ovarian	O Yes	O No
Hyperthyroidism (High Thyroid)	O Yes	O No	Cancer, Renal Cell	O Yes	O No
Hypothyroidism (Low Thyroid)	O Yes	O No	Cancer, Skin	O Yes	O No
HIV Positive	O Yes	O No	Cancer, Stomach	O Yes	O No
			Cancer, Thyroid	O Yes	O No
Surgical History					
Appendectomy (Appendix Removed)	O Yes	O No	Breast Biopsy	O Yes	O No
Cholecystectomy (Gallbladder Removed)	O Yes	O No	Lumpectomy	O Yes	O No
Aortic Valve Replacement	O Yes	O No	Breast Implant	O Yes	O No
Coronary Artery Bypass Graft	O Yes	O No	Breast Reconstruction	O Yes	O No
Aortobifemoral Bypass	O Yes	O No	Lymph Node Resection	O Yes	O No
Carotid Endarterectomy	O Yes	O No	Mastectomy (Breast Removed)	O Yes	O No
Pacemaker, Cardiac	O Yes	O No	Nephrectomy (Kidney Removed)	O Yes	O No
Lung Resection	O Yes	O No	Thyroidectomy (Thyroid Removed)	O Yes	O No
Bladder Surgery	O Yes	O No	Transplant, Kidney	O Yes	O No
Brain Aneurysm	O Yes	O No	Hysterectomy, Partial	O Yes	O No
			Hysterectomy, Total With Bilateral Salpingo-Oophorectomy (BSO)	O Yes	O No

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General/Constitutional			Breast		
Bone Pain	O Yes	O No	Bloody Nipple Discharge	O Yes	O No
Fatigue	O Yes	O No	Breast Lump	O Yes	O No
Fever	O Yes	O No	Breast Pain	O Yes	O No
Night Sweats	O Yes	O No	Breast Swelling	O Yes	O No
New Onset Headache	O Yes	O No	Cracked Nipple	O Yes	O No
Gastrointestinal			Nipple Discharge	O Yes	O No
Blood In Stool	O Yes	O No	Nipple Retraction	O Yes	O No
Ophthalmologic			Red Skin	O Yes	O No
Blurred Vision	O Yes	O No	Skin Dimpling	O Yes	O No
Neurologic			**Hematology**		
Dizziness	O Yes	O No	Easy Bruising	O Yes	O No
Tingling/Numbness	O Yes	O No	HIV	O Yes	O No
Difficulty Speaking	O Yes	O No	Prolonged Bleeding	O Yes	O No
Seizures	O Yes	O No	Recent Transfusion	O Yes	O No
Fainting	O Yes	O No	Weakness	O Yes	O No
Cardiovascular			**Respiratory**		
Heart Attack	O Yes	O No	Blood In Sputum	O Yes	O No
Heart Murmur	O Yes	O No	Cough	O Yes	O No
Swelling In Legs	O Yes	O No	Shortness Of Breath At Rest	O Yes	O No
Chest Pain At Rest	O Yes	O No	Shortness Of Breath With Exertion	O Yes	O No
Chest Pain With Exertion	O Yes	O No	Wheezing	O Yes	O No
Irregular Heartbeat	O Yes	O No	**Social History**		
			Tobacco Use	O Yes	O No

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OB / GYN History	
How old were you when you started your period?	
How old were you when you experienced menopause?	
How old were you with your first pregnancy?	
How many pregnancies have you had?	
How many live births?	
If you have taken oral contraceptives, how many years did you use them?	
If you have taken fertility treatments, how many years did you use them?	
If you have used hormone replacement therapy (estrogen), how many years?	
Social History	
How much caffeine do you drink?	
How much alcohol do you consume a week?	
How many cigarettes do you smoke a week?	
Family History	
Who in your family has had breast cancer?	
Who in your family has ovarian cancer?	
Are you an Ashkenazi Jewish?	O Yes O No
We ask since this subgroup has higher incidence of getting breast cancer	
Allergies	
What medications are you allergic to?	None ___Penicillin ___Sulfa ___Other
Current Medications with Dosages	
Any other relevant medical, surgical, social or family history not listed above?	