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New Patient History Form

Name: ____________________ Age: _______ Occupation: ____________________________
Date: ____________________ Sex: ________ Marital Status: S M W D
Birth Date: ___________________ Primary Care Physician: ____________________________

Chief Breast Complaint: ____

____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

List all ALLERGIES/ADVERSE Reactions: ____

____

List all PRESCRIPTION DRUGS, OVER THE COUNTER, and HERBAL MEDICINES:

____

____

For Women:
Do you or have you taken Birth Control Pills or Hormones? Y N How long? _______

Family History

1. Your Father Alive Deceased
   Age ____ Cause of Death ____________________
2. Your Mother Alive Deceased
   Age ____ Cause of Death ____________________
3. Siblings: Number Living __________ Number Deceased ______________
   Cause of Death ____
4. Biological Children: Number Living __________ Number Deceased ______________
   Cause of Death ____

Your Personal Habits	Yes	No	How Much?
Smoke	___	___	Current _____ Former _____ Never _____
Alcohol	___	___	________________
Exercise	___	___	________________
Caffeine	___	___	________________

Do you have a FAMILY HISTORY of:

	Mother	Father	Sister	Brother	Daughter	Son
Heart Disease	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___
Diabetes-Type 1or 2	___	___	___	___	___	___
Breast Cancer	___	___	___	___	___	___
Ovarian Cancer	___	___	___	___	___	___
Thyroid Disease	___	___	___	___	___	___
Prostate Cancer	___	___	___	___	___	___
Colon Cancer	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Uterine/Cervical Cancer	___	___	___	___	___	___

Other Cancer ____

Other Disease ____

Review of Your Body Systems

Do you currently, or have you had in the past 2 years, any of the following:

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Tuberculosis
___	___	High Blood Pressure	___	___	Pleurisy
___	___	Rheumatic Fever	___	___	Stomach Ulcer
___	___	Heart Murmur	___	___	Gallstones
___	___	Enlarged Heart	___	___	Cancer
___	___	Phlebitis	___	___	Kidney Stones
___	___	Thyroid Trouble	___	___	Kidney Infection
___	___	Diabetes	___	___	Venereal Infection
___	___	Stroke	___	___	Convulsions
___	___	Pneumonia	___	___	Breast Cancer

Who is treating you for these problems? ____

____

Have you recently been troubled with any of the following symptoms?

Yes	No		Yes	No	
___	___	Abdominal Pain	___	___	Swelling of Feet
___	___	Indigestion	___	___	Leg Pain
___	___	Nausea	___	___	Abnormal Bleeding
___	___	Vomiting	___	___	Painful Joints
___	___	Diarrhea	___	___	Fainting Spells
___	___	Constipation	___	___	Cough
___	___	Blood in Stool	___	___	Bloody Sputum

Have you recently been troubled with any of the following symptoms?

Yes	No		Yes	No	
___	___	Recent Change in Bowel Habits	___	___	Wheezing
___	___	Headaches	___	___	Yellow Jaundice
___	___	Double Vision	___	___	Painful Urination
___	___	Nosebleeds	___	___	Blood in Urine
___	___	Difficulty Swallowing	___	___	Slow Urine Stream
___	___	Hoarseness	___	___	Nocturia (frequent urination at night)
___	___	Dizziness	___	___	Pus in Urine
___	___	Shortness of Breath	___	___	Backache
___	___	Chest Pain or Pressure	___	___	Depression/worry
___	___	Irregular Heart Beat			

Do you feel safe in your environment? Yes No

Additional Remarks by Patient: ______________________________

____

Personal History

Your Hospitalizations:

Illnesses	Year	Hospital
________	____	________
________	____	________
________	____	________

Surgeries	Year	Hospital
________	____	________
________	____	________
________	____	________

Tests

	Year Performed		Year Performed
EKG	________	Stool Occult Blood	________
Chest X-Ray	________	Sigmoidoscopy	________
Pap Smear	________	Colonoscopy	________
Breast Exam	________	Blood Sugar	________
Mammogram	________	Tetanus Vaccine	________
Genitalia Exam (men)	________	Polio Vaccination	________
Rectal Exam	________	Small Pox Immunization	________

Have you had a Pneumococcal Vaccination? Yes _____ No _____

WOMEN ONLY

Periods (circle one) Regular or Irregular
Age of first period _______
Date of last period ____________

Do you still have your ovaries? Yes No
Age of Menopause _______

Pregnancies

# of Pregnancies (total) _____
Age at first live birth _____
# of Children born alive _____
#Premature Deliveries _____

Still births _____
Miscarriages _____
of C-Sections _____

Risk for Breast Disease

# of first degree relatives (mother/sister/daughter) who have had breast cancer? ______
Have you ever had a breast biopsy? Yes No
# of previous biopsies ______ Positive or Negative (circle one)
Have you had at least one biopsy with atypical hyperplasia? Yes No
Race or Ethnicity __________________
Have you ever taken Hormone Replacement Therapy? Current___ Former___ Never ___