Breast Care Specialists AMC Christopher S. Sockrider, M.D.

New Patient History Form

Name: _____ **Age:** ___ **Occupation:** _____

Date: _____ **Sex:** ____ **Marital Status: S M W D**

Birth Date: _____ **Primary Care Physician:** _____

Chief Complaint: _____

_____

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

List all <u>ALLERGIES/ADVERSE</u> 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? ___

<u>Family History</u>

1. **Your Father Alive Dead**
   Cause of Death_____
2. **Your Mother Alive Dead**
   Cause of Death_____
3. **Brothers/Sisters** **No. Living** _____
   No. Dead _____
   Cause of Death _____

Do you have a FAMILY HISTORY of:

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Prostate Cancer
___	___	High Blood Pressure	___	___	Colon Cancer
___	___	Diabetes	___	___	Other Cancer _____
___	___	Breast Cancer	___	___	Stroke
___	___	Ovarian Cancer	___	___	Thyroid Disease
___	___	Uterine/Cervical 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 Stone/Kidney
___	___	Thyroid trouble			Infection (circle)
___	___	Diabetes	___	___	Venereal infection
___	___	Stroke	___	___	Convulsion
___	___	Pneumonia	___	___	History of ductal carcinoma in situ or lobular carcinoma in situ (LCIS)

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
___	___	Recent Change in Bowel	___	___	Wheezing
		Habits	___	___	Yellow Jaundice
___	___	Headaches	___	___	Painful Urination
___	___	Double Vision	___	___	Blood in Urine
___	___	Nosebleeds	___	___	Slow Urine Stream
___	___	Difficulty Swallowing	___	___	Nocturia (frequent urination
___	___	Hoarseness			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 Name: _____

Your Hospitalizations:

Illnesses	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Men and Women

Your Children: List any serious diseases in children: _____

No. Living ____

No. Deceased ____ Cause: _____

Your Personal Habits	Yes	No	How Much?
Smoke	___	___	_____
Alcohol	___	___	_____
Exercise	___	___	_____
Caffeine	___	___	_____

WOMEN ONLY Do you still have your ovaries? Y N

Menstrual Periods

Periods: Regular or Irregular (circle)

Age of first menstrual period _____

Date of Last Period _____

Age of Menopause _____

Pregnancies

# of Pregnancies (total) _____

Age at first live birth of child _____

# of Children born alive _____

# of Premature deliveries _____

# of Stillbirths _____

# of Miscarriages _____

# of C-Sections _____

Risk for Breast Disease

_____# of 1°relatives—(mother and/or sister(s)—who have had breast cancer

_____Has patient ever had a breast biopsy? Y N

_____# of previous breast biopsies (positive or negative)

_____Has patient had at least one biopsy with atypical hyperplasia? Y N

_____Race or ethnicity of patient

Tests

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