general physician pc
breast care
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NEW PATIENT HISTORY

Please complete the following questionnaire. Leave blank any parts you are unsure of, or do not wish to answer. Your answers will help with providing your care. We will review this form with you during your examination. All information will be kept confidential.

Patient Name: _____ Date of Birth: _____

Place of Birth (City & State): _____

Social Security Number: _____ Marital Status: _____

Occupation: _____ Employer: _____

Who referred you to our office?_____

Who is your Primary Doctor? _____

Which Pharmacy do you use (Wegmans, CVS, Walmart, etc)_____

What is a good contact number for the doctor to reach you? _____

Emergency contact:_____Relationship:_____

Emergency contact phone number:_____

What is the reason for your visit today?

_____

_____

History of your current problem (when it started, your symptoms and treatment if any**):**

_____

_____

Breast History (abnormal mammogram, breast biopsies or breast surgery in the past**):**

_____

_____

Bra Size: _____

Tobacco Use: ____YES ____NO **Type:** Cigarettes / Pipe / Cigars **No. per day?** ___ **No. of Years:** ___

Smokeless Tobacco: ____Never Used ____ YES ____NO

Quit Date: _____ **Ready to Quit?** ____YES ____NO **Counseling Given?** ____YES ____NO

Alcohol Use: YES / NO Comment: _____

Recreational Drug Use: ____YES ____NO Comment:_____

YOUR MEDICAL HISTORY: Please check all previous illness or conditions below.

____ **Chronic Obstructive Pulmonary Disease**
____ **Asthma**
____ **Hypertension (**High blood Pressure**)**
____ **Coronary Artery Disease**
____ **Myocardial Infarction (**Heart Attack**)**
____ **Congestive Heart Failure**
____ **Hyperlipidemia (**High cholesterol or Triglycerides**)**
____ **Diabetes**
____ **Chronic Renal Failure (**Kidney Disease**)**
____ **Obesity**
____ **Hyperthyroidism (**Overactive Thyroid**)**
____ **Sleep Apnea**
____ **Irregular Heart Beat (Atrial Fibrillation)**
____ **Implanted Defibrillator or Pacemaker**
____ **Hypothyroidism (**Underactive Thyroid**)**
____ **Thyroid Nodule (**Lump in Thyroid Gland**)**
____ **Osteopenia (**Mild Bone Loss**)**
____ **Osteoporosis (**Severe Bone Loss**)**
____ **Vitamin D Deficiency**
____ **Kidney Stones**
____ **Blood Clot in Leg and/or Lung**
____ **Stroke**

Women ONLY

Number of pregnancies:_____ Number of children:_____ Fertility treatments ____ Yes ____No

Did you breast feed? _____ Birth control pills ____Yes ____ No

Implanted birth control (Nexplanon): ____Yes ____No IUD: ____Yes ____ No

Age of first period:_____ Age of menopause:_____ Age of first live birth of child:_____

Natural menopause or surgical (removal of uterus or ovaries): _____

Do you have a history of prior cancers?

_____

_____

Any other problems not listed?

_____

Surgical History:

If so, please include the type of surgery and approximate date:

_____

_____

_____

_____

Have you ever been hospitalized? ____YES ____ NO Hospital: _____

Please tell us reason why and when?

_____

_____

_____

_____

FAMILY HISTORY

Are you adopted? ____YES ____ NO

Has anyone in your family been tested for the BRCA gene mutation? ____YES ____ NO

Has anyone in your family tested positive for the BRCA gene mutation? ____YES ____ NO

If Yes, which family member? _____

Family Medical History			Breast Cancer	Colo-rectal Cancer	Melanoma Skin	Ovarian Cancer	Pancreas Cancer	Prostate Cancer	Stomach Cancer	Uterine Cancer	Other cancer not listed
Relationship	**Age of Diagnosis**	**Alive (A) or Deceased (D)**									
Mother											
Father											
Sister											
Brother											
Maternal Grandmother											
Maternal Grandfather											
Maternal Aunt											
Maternal Uncle											
Paternal Grandmother											
Paternal Grandfather											
Paternal Aunt											
Paternal Uncle											
Daughter											
Son											
Cousin - Male											
Cousin - Female											
Other:											

Current Medications (*include Hormones, Over the Counter drugs, Vitamins and Herbs*):

Name of Medicine	Dosage	How often Taken	Tablet/ Capsule	Reason for Taking Medicine

PAIN MEDICATION- Please list name of pain medication, who prescribes it and what it is for**:**

_____
_____
_____
_____
_____

Are you allergic to anything? ___ YES ___NO

List all ALLERGIES to anything and describe your reaction.

Allergy:	Reaction:

Review of Systems: Please check *all* of the following problems you are having *now*

General
__ Chills
__ Fever
__Decreased Appetite
__ General Discomfort/ Fatigue
__ Night Sweats
__Pain (Location: _____)
__Weakness
__Weight Gain
__Weight Loss
__Falls

Endocrine
__ Cold Intolerance
__Heat Intolerance
__Diabetes
__Polydipsia (Excessive thirst)
__Hot Flashes

Eyes
__Blurred Vision
__ Double Vision
__Eye Pain
__Tearing
__Vision Changes
__Yellow Eyes

Genitourinary
__Blood in Urine
__Burning Urination
__Difficulty Controlling
__Excessive Urination
__Frequency
__Sexual Dysfunction
__Urgency
__Vaginal Bleeding
__Incontinence

Musculoskeletal
__Back Pain
__Bone Pain
__Joint Pain
__Joint Stiffness
__Muscle Pain
__Muscle Weakness
__Neck Pain
__Trauma / Injury (_____)

Hem/Lymph
__Anemia
__Easy Bruise/Bleed
__Lymphedema (Swelling)
__Swollen Glands

Head/ Ears/Nose/ Throat
__Hearing Changes
__Hearing Loss
__Hoarseness
__Mouth Ulcers
__Nose Bleeds
__Otalgia (Ear pain)
__Ringing In Ears
__Runny Nose
__Sore Mouth
__Throat Pain

Respiratory
__Cough
__Coughing Blood
__Shortness Of Breath
__Sputum Production
__Wheezing
__Pleuritic (Chest) Pain

Psychiatric
__Depression
__Hallucinations
__Insomnia
__Anxiety
__Suicidal Thoughts

Gastrointestinal
__Abdominal Pain
__Black Stools
__Blood in Stools
__Constipation
__Diarrhea
__Difficulty Swallowing
__Heartburn
__Nausea
__Painful Swallowing
__Vomiting

Neurological
__Confusion
__Dizziness
__Fainting
__Headache
__Lightheadedness
__Memory Changes
__Numbness: _____
__Paresthesia "pins & needles" feeling
__Seizure
__Speech Changes
__Unbalanced Walking

Breast
__Breast Pain
__Breast Mass
__Nipple Discharge
__Breast Self-Exam
__Skin Changes

Skin
__Bruises
__Bumps
__Changes In Moles
__Itching
__Nail Changes
__Rash
__Skin Changes
__Sores

Cardiovascular
__Chest Pain
__Palpitations
__Leg Swelling
__Leg Pain
__Paroxysmal Nocturnal Dyspnea (Shortness of breath & coughing @ night)
__Orthopnea

Patient Signature:_____ Date:_____

Physician/Healthcare Provider Signature:_____