

## Advanced Breast Treatment Medical History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**Why are you here today?** \_\_\_\_\_

Please describe more fully which breast is affected, how long you've known about this, and list any tests you've had for this.

**Past Medical History:**

Do you have presently or have you ever been treated for:

	Yes	No		Yes	No
Asthma			Glaucoma		
Blood Clots			Hepatitis		
Cataracts			High Cholesterol		
Stroke			HIV		
Bleeding Problems			High Blood Pressure		
Chronic Bronchitis			Thyroid Disease		
Heart Disease			Kidney disease		
Diabetes			Osteoporosis		
Emphysema			Seizure		
Acid Reflux			Tuberculosis		

Any other serious health issues:

**Past Surgical History:**

Please list all surgeries you have had and their approximate dates:

(Please include all breast biopsies even if they were needle biopsies)

**Medications:** Please list ALL medications you take with their doses and frequency. Please include over the counter medications you take regularly.

**Allergies:** include medications, latex, adhesives, etc. and how they affect you:

**Family History:**

Please list any diseases that run in your family including breast and ovarian cancer:  
(Please include approximate age at diagnosis for any cancers)

**Menstrual History:**

Age at first period \_\_\_\_\_ Date of LMP: \_\_\_\_\_  
Age at birth of first child \_\_\_\_\_ Age at menopause \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_  
Are you pregnant or could you be pregnant now? Y N  
Do you take hormones? Y N  
If yes, what do you take? \_\_\_\_\_ For how long? \_\_\_\_\_  
If no, did you ever? Y N  
If yes, for how long and when did you quit? \_\_\_\_\_

**Social History:**

Do you smoke? Y N  
If yes, what do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_  
For how long? \_\_\_\_\_  
If no, did you ever smoke? Y N When did you quit? \_\_\_\_\_  
Do you drink alcohol? Y N  
If yes, what do you drink? \_\_\_\_\_ How many per day? \_\_\_\_\_  
Do you use any street drugs? Y N  
If yes, what do you use? \_\_\_\_\_ How often? \_\_\_\_\_

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**Review of Systems:**

Do you have or have you had recently:

	Yes	No
Fever or chills		
Blurred vision		
Sore throat		
Sinus pain		
Shortness of breath		
Wheezing		
Constipation		
Diarrhea		
Jaundice		
Blood in stool		
Difficulty with urination		
Rash/itching		
Numbness/tingling		
Shortness of Breath		
Joint pain		
Heat/cold intolerance		
Excessive thirst		
Unexplained weight change		
Anxiety/depression		
Easy bleeding/bruising		
Enlarged lymph nodes		
Chest pain		
Any other important change please list:		

Who is your family doctor? \_\_\_\_\_

Who is your Ob/Gyn doctor? \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Thank you for taking the time to provide this important information!



