TEXAS BREAST SPECIALISTS
Higher Standards. Greater Hope.

Name: _____ Date of Birth: _____ Date: _____

Updated Patient Questionnaire

Telephone Number: _____ **Referring Physician:** _____

Primary Physician/Gynecologist: _____

Reason for your visit today: _____

Do you have any NEW medical conditions? Circle all that apply.

High blood pressure	Diabetes	Sleep Apnea
Heart Attack	Kidney Disease	Seizures
Irregular Rhythm	Liver Disease	Depression
Heart Failure	Asthma/COPD	Other psychiatric illness
High Cholesterol	Crohn's/Ulcerative Colitis	Dementia
Vascular Disease	Gastric Reflux	Arthritis
Blood Clots (PE/DVT)	Hypothyroidism	Osteoporosis
Other (Explain):		

Any NEW Surgeries:

Date	Operation

Any NEW Family Cancer History – particularly breast (male and/or female), ovarian, colon, uterine, melanoma, prostate, or pancreas:

Relation	Maternal or Paternal	Type of Cancer	Age at Diagnosis

Circle all that apply: Smoke – Yes or No Drink Alcohol – Yes or No Other Drug Use – Yes or No

Married Single Divorced/Separated Widowed Other

Review of Systems – circle all that apply:

Weight Loss	Abdominal Pain	Inability to fall asleep
Weight Gain	Change in Bowel Habits	Anxiety
Feel Poorly/Malaise	Rectal Bleeding	Depression
Chills	Nausea/Vomiting	Dizziness/Falls
Fever > 101	Urinary Incontinence	Confusion
Hoarseness	Urinate > 2x/night	Numbness
Hearing Loss	Blood in urine	Headache
Chest Pain	Menstrual irregularity	Always thirsty
Palpitations	Vaginal discharge	Joint pain
Leg Swelling	Hot Flashes	Back pain
Shortness of Breath	Itching	Neck pain
Cough	Rash	Muscle aches
Other (Explain):		