TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

Patient Name:_____ Date of Birth:_____ Age:_____ Sex: M F

Drug Allergies:_____

Height:_____ Weight:_____ Bra Size:_____ Date of last flu shot:_____ Occupation:_____

Primary Care Physician (**First and Last Name**)_____Phone #_____

OG/GYN Physician (**First and Last Name**)_____Phone #_____

Reason for Consultion:_____

Please list any previous surgeries and their dates:_____

_____

_____

Age at 1rst menstrual period:_____ # of Pregnancies:_____ # of Live Births:_____ Age at 1rst birth:_____

Are you currently pregnant or breastfeeding?(circle what applies) Do you use birth control? Y N

Age at menopause:_____ Natural / Surgical Do you use hormone replacements therapies or have in the past? Y N

Please circle all that apply to YOU:

Heart Problems High Blood Pressure Diabetes Stroke Cancer Arthritis Auto Immune Disorder

Bleeding Problems Kidney Problems Hepatitis Liver Problems Asthma Lung Problems Seizures

Stomach Problems Thyroid Dizziness/Fainting Spells Mental Illness/Depression Problems with Anesthesia

Bleeding Disorder MRSA HIV Other:_____

_____

_____

_____

Family History:(List family members that were diagnosed with cancer, the type of cancer with their age of diagnosis and if they were on your mother's or father's side of the family)

_____

_____

_____

Do you smoke? If YES, How many years?_____ Amount per day?_____ Are you a former smoker? Y N

If YES, How many years did you smoke?_____ When did you quit?_____

Do you drink alcohol? If YES, How much and how often?_____

Do you use any recreational drugs? If YES, What kind and how often?_____

When was your last mammogram and/or ultrasound?_____ Where was it performed?_____

Do you have an allergy to contrast dye? Y N Are you claustrophobic? Y N

Do you have any metal in your body other than dental?_____

List a good contact number for us to reach you with results: _____

Person(s) that may have access to your Medical Records: List their full name, relationship and telephone number:

_____

_____

Pharmacy Name, Number & Address:_____

Please list any medications or supplements that you are currently taking:

Name	Dosage	How Often

I certify that the information I have provided is correct. I will not hold my doctor or members of the staff responsible for any errors omissions that I have made in completion of this form.

Patient Signature:_____ Date:_____