TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

Name: _____ Date of Birth: _____

Date: _____ MRN: _____

Physicians:

Referring _____ OB/GYN _____

Primary Care _____ Others _____

Please state in your own words the reason for your visit:

_____

_____

_____

BREAST HISTORY

Please complete the below table:

	Left Breast	Right Breast
Abnormal mammogram		
Abnormal ultrasound		
Biopsy (date and results)		
Aspiration (date and results)		
Cancer		
Surgery		
Sentinel Lymph Node Biopsy		
Axillary Lymph Node Dissection		
Lymphedema		
Plastic Surgery		

Patient Name: _____ DOB:_____

DOS:_____

Please indicate any medical problems you have:

☐ Hypertension ☐ Diabetes Mellitus ☐ Heart Disease ☐ Psychiatric History
☐ Asthma/COPD ☐ Reflux/Indigestion ☐ Thyroid Problems
☐ Bleeding/Blood Clotting Problems ☐ Prior Cancer ☐ Previous Chest Radiation

If you marked yes to any of the above, please describe:

_____
_____

Any Other Medical Problems: _____
_____

Please List any Prior Surgeries (including dates, name of surgeon and/or hospital):

_____
_____
_____

GYN HISTORY:

Last Menstrual Period _____ **Age of First Period**_____

Number of Pregnancies _____ **Number of Births**_____

Number of Miscarriages/Abortions _____ **Age of First Delivery**_____

Did you breastfeed? Y ☐ N ☐ **For how long (per child)?**_____

Oral Contraceptive use? Y ☐ N ☐ **For how long (in lifetime)?_** _____

Hormone Replacement Therapy? Y ☐ N ☐ **For how long?** _____
Combination Progesterone/Estrogen or Estrogen alone? _____ **Llast taken:** _____

FAMILY HISTORY:

Please list any family members with cancer:

Type of Cancer	Relation	Mother's side	Father's side	Age at diagnosis	Treatments	Genetic Testing	Current Age

Patient Name: _____ DOB:_____
DOS:_____

Please give the dates of the most recent:

Colonoscopy_____ **Bone Density Exam**_____
Pelvic exam_____ **Flu shot**_____

SOCIAL HISTORY:

Occupation _____
Married _____ **Single** _____
Current Tobacco Use? **Y** ☐ **N** ☐ **Packs per Day**_____ **Years**_____
Alcohol Use? **Y** ☐ **N** ☐ **Drinks per Week**_____
Caffeine Use? **Y** ☐ **N** ☐ **Drinks per Day**_____
Illicit Drug Use? **Y** ☐ **N** ☐ **Type/Frequency**_____
Social Support? **Y** ☐ **N** ☐
Do you exercise? **Y** ☐ **N** ☐ **Days per Week** _____ **Type**_____
Mechanisms to deal with stress? _____

Medications/Vitamins/Supplements/Herbal/Holistic Treatments (include dose and frequency):

_____
_____
_____

Do you take blood thinners, aspirin, anti-inflammatories (Motrin, Ibuprofen), steroids or immunosuppressants? Yes__☐__ **No**___☐___
Please list Name, Dose, Frequency and date last taken:

_____
_____
_____

Please List any Allergies and Reactions:

_____
_____
_____

PHARMACY:

Name_____
Address/Cross Streets_____
Will you allow Texas Breast Specialists to obtain your medication history electronically from your pharmacy?
☐ **Yes** ☐ **No**

I certify that this information is correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____