TEXAS BREAST SPECIALISTS
Higher Standards • Greater Hope

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PATIENT NAME:_____ AGE / DATE OF BIRTH:_____
What do you prefer to be called? _____

What is your understanding of why you are being seen?_____
_____
Symptoms related to above?_____
_____

REVIEW OF SYSTEMS: PLEASE CHECK THE SYMPTOMS YOU ARE EXPERIENCING.

GENERAL:
____chills
____fatigue
____fever
____night sweats
____weight gain > 10 lbs
____weight loss > 10 lbs
____nausea

SKIN:
____bruising
____rash
____color changes

HEENT:
____headache
____blurred vision

NECK:
____mass or lump
____swollen glands

RESPIRATORY:
____chronic cough
____difficulty breathing

BREAST:
____breast mass
____breast pain
(if yes, rate 1-10)
____breast swelling
____nipple discharge
____nipple pain
____skin changes
____change in breast size

CARDIOVASCULAR:
____chest pain
____irregular heart beat
____rapid heart rate
____shortness of breath

GASTROINTESTINAL:
____abdominal pain
____black tarry stools
____bloody stools
____change in bowel habits
____constipation
____diarrhea
____vomiting

FEMALE GU:
____abnormal vaginal bleeding
____menstrual irregularities
____pelvic pain
____urinary complaints
____vaginal discharge

MUSCULOSKELETAL:
____bone pain
____muscle pain

NEUROLOGIC:
____headaches
____numbness
____weakness

PSYCHIATRIC:
____anxiety
____depression
____insomnia
____panic attacks
____suicidal ideation

ENDOCRINE:
____cold intolerance
____hair changes
____heat intolerance
____hot flashes
____libido changes

HEMATOLOGY:
____abnormal bleeding
____anemia
____easy bruising
____enlarged lymph nodes
____nose bleeds
____prolonged bleeding

MALE GU:
____lump in testicle
____penile discharge
____prostate conditions

OTHER SYMPTOMS:
_____
_____
_____
_____
_____
_____
_____
_____

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PATIENT NAME_____ DATE OF BIRTH _____

PHYSICANS:

Referring Physician_____
Primary care Physician_____
Gynecologist_____
Other physicians you wish us to update
_____

FAMILY HISTORY: (*list family member, if on your mother's or father's side, and* ***age of their diagnosis***)

Breast Cancer _____
_____
_____
_____
_____

Ovarian Cancer _____
_____
_____
_____

Other Cancers_____
_____
_____
_____

Other significant family history (heart disease, diabetes, etc.)
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS: list all prescription medications, vitamins, supplements and over the counter medications with dosage
_____
_____
_____
_____
_____
_____

ALLERGIES (please list your reaction to each medication)
_____
_____
_____

Do you have an allergy to a contrast medium/dye? Y / N
Do you have an allergy to shellfish? Y / N
Are you claustrophobic? Y / N
Do you have an implanted devices? (pacemaker, bladder stimulator, metal plate/ rods, etc.) Y / N
Do you have an Advance Directive Document? Y / N
Would you like to provide a copy of the above? Y / N
If you have Medical Power of Attorney, list name below:
_____
If you have a Financial Power of Attorney, list name below:
_____

PHARMACY NAME:_____
PHONE NUMBER:_____
ADDRESS:_____

Please list a good contact telephone number(s) for me to reach you, if more than 1, list in order of preference.
_____
If you do not answer the number listed, is it ok to leave a message? Y / N

SOCIAL HISTORY:
Occupation _____ Marital Status _____
Children (list their names/ages) _____
Religious Preference _____

Answer "Yes" / "No" to the following. (If "Yes", indicate amount and how many times per day or week)
____Caffeine_____
____Tobacco (Please circle one below)
Never / Previous / Current -- If so, list # of PPD ___
____Alcohol_____
____Illicit drugs_____
____Exercise_____
Do you use a cane/walker/wheelchair? Y / N, if Y, circle one

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

Patient Signature:_____ Today's date:_____

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ADDITIONAL HISTORY

BRA SIZE _____

LAST MENSTRUAL PERIOD_____

AGE AT FIRST PERIOD_____

DATE OF LAST PAP SMEAR_____

METHOD OF CONTRACEPTION_____
ARE YOU PREGNANT? Y / N
ARE YOU BREAST FEEDING Y / N

AGE AT FIRST PREGNANCY_____

AGE AT FIRST LIVE BIRTH_____

# of PREGNANCIES / LIVE BIRTHS_____

AGE AT MENOPAUSE_____

HORMONE REPLACEMENT THERAPY currently?
Y / N
History of HORMONE REPLACEMENT THERAPY?
Y / N

If yes, how long? _____

Do you do breast self exams? Y / N

PAST SURGICAL HISTORY (list year performed if able)
____Appendectomy
____Back surgery
____Breast biopsy
____Breast implants (list type if known) _____
____Cataracts
____C-section
____ Colon surgery
____Gallbladder surgery
____Heart surgery
____Hemorrhoid surgery
____Hysterectomy (removal of the uterus)
- Do you still have your ovaries? Y / N

____Hernia repair (list type) _____
____Lumpectomy
____Mastectomy
____Splenectomy
____Thyroidectomy
____Tonsillectomy
OTHER SURGERIES (list year performed if able)
_____
_____

OTHER MEDICAL CONDITIONS AND DIAGNOSISES

____Arthritis
____Asthma
____Atrial fibrillation / Atrial Flutter (circle which one if so)
____Bleeding disorder
____Chest pain
____Congestive heart failure
____Chronic lung disease (COPD)
____Diabetes mellitus (DM)
____Emphysema
____ Gastroesophogeal reflux disease (GERD)
____Heart disease
____ Past heart attack
____ High blood pressure (Hypertension)
____ High cholesterol (hypercholesterolemia)
____History of cancer _____
____HIV positive
____Hyperthyroidism (high)
____hypothyroidism (low)
____ History of blood clots
____ Hepatitis
____Mental Illness (Anxiety/Depression/Biploar Disorder)
____Seizures
____Stroke
____Transient ischemic attack (TIA)
____Tuberculosis (TB)
____Recent Hospitalization(s)?
____OTHER (list below)
_____
_____
_____
_____
_____
_____
_____

Have you had your flu shot this season? Y / N

Have you ever had any problems with anesthesia? Y / N
If so, please list.
_____

Can you walk a block or climb a flight of stairs without getting short of breath? Y / N