Dr. Caroline Coombs-Skiles **Patient's MRN:**

TEXAS BREAST SPECIALISTS
Higher Standards • Greater Hope

Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____ Age: _____

Referring Physician _____ OB/GYN _____

Primary Care _____ Others _____

Please indicate any medical problems you have:

___Hypertension ___Diabetes Mellitus ___Heart Disease ___Psychiatric History

___Asthma/COPD ___Reflux/Indigestion ___Thyroid Problem ___Previous Chest Radiation

___Bleeding/Blood Clotting Problems ___Prior Cancer

Any Other Medical Problems:

_____ _____

_____ _____

_____ _____

Please List any Prior Surgeries (including date):

_____ _____

_____ _____

_____ _____

GYN HISTORY:

Age at First Period_____ Number of Pregnancies_____ Number of Births _____
Age of First Delivery_____ Age of Menopause _____

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? _____Last Taken_____

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

_____ _____

_____ _____

_____ _____

_____ _____

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Do you take blood thinners, aspirin, anti-inflammatories (Motrin, Ibuprofen), steroids or immunosuppressants? Yes_____ No_____

Please List any Allergies and Reactions:

_____

_____

FAMILY HISTORY - Please list any family members with cancer:

Type of Cancer	Relation	Mother's Side	Father's Side	Age at Diagnosis

SOCIAL HISTORY:

Occupation: _____

Married _____ Single ____ Widowed _____

Current Tobacco Use? Y N Packs per Day_____ Years_____

Alcohol Use? Y N Drinks per Week_____

Illicit Drug Use? Y N Type/Frequency_____

Number of Children _____ Ages _____

PHARMACY:

Name_____ Phone number _____

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: _____