PATIENT INFORMATION **Amy B. Eastman, M.D.**

DATE: ________________ **NAME:** ____
Who sent you? ____

What is your current problem? ____
____

Do you have a history of:

____ High Blood Pressure ____ Heart Disease ____ Hepatitis
____ Cancer ____ Breast Disease ____ HIV Infection
____ Diabetes ____ Bleeding problems ____ Blood transfusion
____ Other: (Specify) ____

Family History of: (Please list) ____
____

Please list all of your surgeries with dates:

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Please list all medications you are currently taking:

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Please list your drug allergies:

1. ________________ 2. ________________ 3. ________________
4. ________________ 5. ________________ 6. ________________

What is your occupation? ______________________ **How long?** __________

Do you:

____ Smoke? How much? ________________ ____ Diet pills? What kind? ________________
____ Drink alcohol? How much? ________________ ____ Take drugs? Which ones? ________________

Have you recently had any of the following?

____ Weight loss	____ Nausea	____ Rash	____ Weight gain
____ Vomiting	____ Weakness	____ Fever	____ Abdominal pain
____ Headache	____ Chills	____ Seizure	____ Bleeding problem
____ Change in appetite	____ Depression	____ Vision change	____ Constipation
____ Hearing loss	____ Blood in stool	____ Blood in urine	____ Painful urination
____ Vaginal discharge	____ Nose bleeds	____ Neck pain	____ Painful joints
____ Heart palpatations	____ Leg swelling	____ Swollen glands	____ Chest pain
____ Nipple discharge	____ Edema	____ Asthma	____ Breast lump
____ Jaundice	____ Shortness or breath	____ Itching	____ Hay fever
____ Pneumonia	____ Change in mole	____ Allergy to food	____ Allergy to iodine

BREAST HEALTH QUESTIONNAIRE

Amy B. Eastman, M.D.

Current breast complaint:____

Previous breast problems: ____Yes ____No

If yes, Diagnosis/Date: ____

Previous breast biopsy: ____Yes ____No

If yes, Diagnosis/Date: ____

Previous breast surgery? ____Yes ____No

If yes, Procedure/Date: ____

Date of last mammogram: ________________________ Was your mammogram normal?: ____Yes ____No

Family History of Breast Cancer? ____Yes ____No Ovarian Cancer? ____Yes ____No

If yes for either breast or ovarian cancer, please complete table below:

Relative	Breast (check if yes)	Age at Diagnosis	Ovarian (check if yes)	Age at Diagnosis
Mother				
Sister				
Daughter				
Maternal grandmother				
Maternal aunt				
Paternal grandmother				
Paternal aunt				
Other:______________________				

Other cancers in the family:

____

____

Reproductive History

Menstrual History: ____Regular ____Irregular ____Stopped Date of last menstrual cycle: ________

Age of onset of menses: ______

Number of pregnancies: ______ Number of Live Births: ______ Age at First Live Birth: ______

Did you breastfeed your children?: ____Yes ____No If yes, cumulative duration: ________________

Oral contraceptives: ____Yes ____No If yes, prescription name: ______________________________

Current use: ____Yes ____No Duration: ________

Hysterectomy: ____Yes___No Date: __________ Ovaries removed: ____Left ____Right ____Both

Hormone replacement therapy: ____Yes ____No If yes, prescription name: ________________________

Current use: ____Yes ____No Duration: _______