TEXAS BREAST SPECIALISTS

Name: _____Date of Birth: _____Age: _____

Which Physician referred you to our office: _____

Primary Physician/Internist: _____ Phone: _____

OB/GYN: _____ Phone:_____

Reason for visit:_____ How long have you had this condition or symptoms? _____

Date of your most recent mammogram? _____Where was it performed?_____

Medical History (Do **YOU** have a history of any of the following?)

	YES	NO	
Cancer	◯	◯	Type: _____
Diabetes	◯	◯	
Heart Trouble	◯	◯	Type: _____
Pacemaker/Defibrillator	◯	◯	
High Blood Pressure	◯	◯	
Stroke/TIA/Mini Stroke	◯	◯	When: _____
Migraines	◯	◯	
Hardware/Metal Implants	◯	◯	Location: _____
Seizures/Epilepsy	◯	◯	
Blood Thinner Use	◯	◯	
Bleeding Disorders	◯	◯	
Blood Thinner Use	◯	◯	
Asthma	◯	◯	
Alcoholism/Sub Abuse	◯	◯	
Thyroid Disease	◯	◯	Type: _____
Scleroderma	◯	◯	
Autoimmune Disease	◯	◯	Type: _____
Anxiety/Depression	◯	◯	

BREAST HISTORY

Have you had any breast surgery before? YES ◯ NO ◯

If yes, what kind? _____

Surgeon/Facility_____ Date: _____

What was your diagnosis?

◯ Benign
◯ Cancer
◯ LCIS(lobular carcinoma in situ)
◯ Fibroadenoma
◯ Unknown
◯ Fibrocystic Disease
◯ DCIS(ductal carcinoma in situ)
◯ Atypical Hyperplasia
◯ Cosmetic Only

SURGICAL HISTORY

What other surgeries have **YOU** had? (Please include dates)

_____

_____

REPRODUCTIVE HISTORY

How old were you when you started your period? _____ Date of last period? _____

Number of pregnancies? _____Number of births? _____ Your age at first live birth?_____

History of nursing? Yes ◯ No ◯ How long? _____ What method of birth control are you using? _____

How old were you when you went through menopause?_____

Have you taken any of the following hormones?

Birth control pills/Depo Provera YES ◯ No ◯ if yes, how long? _____

Hormone replacement therapy YES ◯ No ◯ if yes, how long? _____

Fertility Treatments YES ◯ No ◯ if yes, how long? _____

SOCIAL HISTORY

Are you currently smoking? YES ◯ No ◯ if yes, how long? _____

Have you ever smoked? YES ◯ No ◯ if yes, how long? _____

How any cigarettes do or did you smoke per day? _____

Do you drink alcohol? YES ◯ No ◯ if yes, how many drinks per week? _____

Do you use recreational drugs(i.e. marijuana, cocaine, etc.)? YES ◯ No ◯

FAMILY HISTORY

Are you of Ashkenazi Jewish Ancestry? YES ◯ No ◯

Has a relative in your family had breast cancer? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Has any relative in your family had ovarian cancer? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Has any relative in your family had prostate cancer? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Has any relative in your family had melanoma? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Has any relative in your family had pancreatic cancer? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Has any relative in your family had colon cancer? YES ◯ NO ◯

Relationship? _____ Maternal/Paternal? _____ Age of Diagnosis:_____ Age of Death:_____

Does your family have a history of any other cancers? YES ◯ NO ◯

If yes, list below:

_____

_____

_____

_____

REVIEW OF SYMPTOMS – Have YOU experienced any of the following **recently**?

Headaches	YES ◯	No ◯	
Night Sweats or Hot Flashes	YES ◯	No ◯	
Fevers	YES ◯	No ◯	
Chills	YES ◯	No ◯	
Chest Pain	YES ◯	No ◯	
Shortness of Breath	YES ◯	No ◯	
Abdominal Pain	YES ◯	No ◯	
Nausea	YES ◯	No ◯	
Vomiting	YES ◯	No ◯	
Diarrhea	YES ◯	No ◯	
Blood in Stool	YES ◯	No ◯	
Difficulty with Urination	YES ◯	No ◯	Type: _____
Swelling, Numbness, Tingling in arms or legs	YES ◯	No ◯	Location: _____
Back/Joint Pains	YES ◯	No ◯	Location & side: _____
Unexplained weight loss	YES ◯	No ◯	
Difficulty sleeping	YES ◯	No ◯	
Anxiety	YES ◯	No ◯	
Depression	YES ◯	No ◯	
Suicidal Ideas	YES ◯	No ◯	
Breast Lumps/masses/nodules	YES ◯	No ◯	
Breast pain/tenderness	YES ◯	No ◯	
Nipple Discharge	YES ◯	No ◯	
Breast Skin Changes	YES ◯	No ◯	
Nipple Inversion	YES ◯	No ◯	
Breast Shape Changes	YES ◯	No ◯	

I certify that all the information submitted by me is true and complete to the best of my knowledge.

Patient Signature: _____Date: _____

Allergies

Medication	Describe Reaction
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list the names and dosages of all medications that you are currently taking.

Medication	Strength	Dose	How many times a day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over the counter or vitamins/mineral supplements you are currently taking. (Multi vitamin, Fish oil)

Medication	Strength	Dose	How many times a day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*****Are you taking Aspirin, any blood thinning medications, Vitamin E, NSAIDS, and/or fish oil now or within the last 10 days?****** **YES ◯** **No ◯**

If yes, when was your last dose? _____

Please list the name, address and phone number of any other physicians involved in your medical care:

Physician Name	Address	Phone
_____	_____	_____
_____	_____	_____

Please list the name, address and phone number of your preferred local pharmacy:

Pharmacy Name	Address	Phone
_____	_____	_____