## MEDICAL HISTORY

Name: _____ Date of birth: ___/___/____ Age:_____

Single Married Widowed Race:_____

Religious preference:_____ Occupation: _____

Referred by: _____

Reason you came for evaluation:_____

| | RIGHT | LEFT |
|---|---|---|
| Lumps in breast now? | _____ | _____ |
| Nipple discharge? | _____ | _____ |
| Breast pain or soreness? | _____ | _____ |
| Injury to the breast? | _____ | _____ |

Give details including when and how discovered:_____

_____

Have you had a mammogram previously?_____ Date(s):_____

If yes, where? _____ Results:_____

List previous breast surgery or problems: type of procedure, date, and physician: _____

_____

Number of previous breast biopsies? _____

Do you practice breast self exams? _____ How often? _____

Do you have a history of smoking?_____ Are you currently smoking?_____
How many years? _____ How much? _____

How many alcoholic beverages do you average each week? _____Or month? _____

How many caffeine-containing beverages do you consume each day? _____

Do you have a history of cancer other than breast?_____ If yes, list type, age, physician, treatment:

_____

Family history of breast cancer? Yes____ No _____

| | | Age | | | Age |
|---|---|---|---|---|---|
| Mother | ____ | ____ | Maternal Grandmother | ____ | ____ |
| Sister | ____ | ____ | Paternal Grandmother | ____ | ____ |
| Daughter | ____ | ____ | Maternal Aunt | ____ | ____ |
| | | | Paternal Aunt | ____ | ____ |

Family history of other cancers: (i.e. colon, ovarian, prostate, melanoma, other) Give details, type and age.

_____

_____

Name :_____ Date: _____

| | | Yes | No | Dates |
|---|---|---|---|---|
| Do you take or have you taken: | Birth control pills | _____ | _____ | _____ |
| | Estrogen | _____ | _____ | _____ |
| | Progesterone | _____ | _____ | _____ |
| | Cortisone | _____ | _____ | _____ |

Age of first menstrual cycle:_____
Date of last period:_____
Age of menopause:_____

Give number of pregnancies:_____ Age of first pregnancy _____
Number of live births:_____ Are you pregnant?_____
Did you breast feed? _____ If yes, how long? _____

Have you had a hysterectomy?_____ Date _____
Reason:_____ Surgeon _____

Have your ovaries been removed? _____ Date_____
Reason _____ Surgeon _____

What is your height? _____ Weight _____

Are you being treated for diabetes, heart problems, bleeding disorders, or other medical conditions? Indicate anything you are under a physician's care for and the physician's name.

_____

_____

Previous surgery other than breast? List procedure, date and surgeon.

_____

_____

Prescription medicines? Name of medication, dosage, how often taken.

_____

_____

Do you take aspirin regularly?_____

Do you take pain relievers or other "over the counter" supplements or medications? If yes, list.

_____

Drug allergies? _____

List drug reaction? _____

Tape or soap allergies?_____ Details:_____

Patient #: _____

# Texas Oncology, P.A.

**Review of Systems:** Please indicate if you have any of the following problems now or in the past. If no problems are present in a category, please circle the bold heading.

**Height:** _____ **Weight:** _____ **lbs**

**Constitutional**
Fever ____
Night sweats ____
Weight gain (___) lbs
Weight loss (____) lbs
Exercise intolerance ____

**Eyes**
Dry eyes ____
Irritation ____
Vision Change ____

**ENMT**
Difficulty hearing ____
Ear pain ____
Frequent nosebleeds ____
Nose/Sinus problems ____
Sore Throat ____
Bleeding gums ____
Snoring ____
Dry mouth ____
Mouth Ulcers ____
Oral abnormalities ____
Teeth abnormalities ____

**Cardiovascular**
Chest pain ____
Arm pain on exertion ____
Shortness of breath when walking ____
Shortness of breath when laying down ____
Palpitations ____
Known heart murmur ____
Chest pain on exertion ____
Arm pain on exertion ____

**Respiratory**
Cough ____
Wheezing ____
Shortness of breath ____
Coughing up blood ____

**Gastrointestinal**
Abdominal pain ____
Vomiting ____
Normal appetite ____
Diarrhea ____
Vomiting blood ____
Constipation ____

**Genitourinary**
Incontinence ____
Difficulty urinating ____
Hematuria ____
Urinary frequency ____
Increased frequency ____
Urinary loss of control ____
Incomplete emptying ____

**Musculoskeletal**
Muscle aches ____
Muscle weakness ____
Arthralgias/joint pain ____
Back pain ____

**Skin**
Abnormal mole ____
Jaundice ____
Eczema ____
Rash ____

**Neurology**
Loss of consciousness ____
Weakness ____
Numbness ____
Seizures ____
Dizziness ____
Headaches ____

**Psych**
Depression ____
Mania ____
Sleep disturbance ____
Feeling unsafe in relationship ____
Alcohol abuse ____

**Endocrine**
Fatigue ____
Increased thirst ____
Hair falling out ____
Increased hair growth ____

**Hematology/Lymphatic**
Swollen glands ____
Bruising ____
Bleeding problems ____

Allergy/Immunologic
Runny nose ____
Sinus pressure ____
Itching ____
Hives ____
Frequent sneezing ____

**Other Medical Problems:** _____

_____

_____