PRATT HEALTHCARE

Patient History Form: Breast Surgical Oncology

Please complete the following questions regarding your Medical History as thoroughly as possible. This will allow you a comprehensive visit with the provider.

Please note: You will be asked to verify this information at your visit for accuracy.

Name: _____ Date of Birth: _____

PCP: _____ GYN: _____

Please describe the reason for your appointment:

_____

_____

Have you ever been diagnosed with cancer? _____ if yes, what type? _____

Have you ever had a Breast Biopsy? _____ Date: _____ Facility: _____

Have you ever had Breast Surgery? _____ Date: _____ Facility: _____

Date of your last:

Mammogram: _____ Ultrasound _____ MRI _____

Medical History:

Do you have any of the following?

Heart:
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Attack
- ☐ Angina
- ☐ Chronic Heart Failure

Kidney:
- ☐ Diabetes
- ☐ Chronic Renal Failure

Lungs:
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of breath

Liver:
- ☐ Hepatitis
- ☐ Cirrhosis

Thyroid:
- ☐ Hyperthyroid
- ☐ Hypothyroid

Blood:
- ☐ Bleeding Disorder
- ☐ HIV/AIDS
- ☐ Anemia
- ☐ Sickle Cell
- ☐ History of clots

Please list any surgeries you have had:

_____

_____

Have you ever had complications with Anesthesia? _____

List hospitalizations for any reason:

_____

_____

(Please turn over to complete page 2)

List all medications (prescription or over the counter):
_____
_____

What allergies to medications do you have?
_____
_____
What is the reaction? _____

Social History:
Marital Status: _____
Do you use tobacco presently or in the past? _____ Packs per day: _____
Do you consume alcohol? _____ How many drinks per day? _____
Do you use illicit drugs presently or in the past? _____ What type: _____
Do you exercise? Yes ____ No ____ What type of exercise? _____

OB/GYN History:
Menarche:
How old were you when you had your first period? _____
When was your last period? _____
Have you gone through or are you having symptoms of menopause? _____
If yes, at what age? _____
Date of your last GYN/Pap Smear: _____
Are you on oral birth control? _____
Present or Past: _____ If yes, how long? _____ Last taken: _____
Have you ever taken Estrogen Replace Therapy? _____
Present or Past: _____ If yes, how long? _____ Last taken: _____
Have you ever taken Tamoxifen/ Aromatase Inhibitor? _____
If yes, for treatment or prevention? _____
Have you ever been pregnant? _____ If yes, how many times? _____
How many live births? _____ Miscarriages? _____
Age at your first full term pregnancy: _____
Breast feeding, past or present? _____
Have you or any family members ever been tested for the BRCA Gene Mutation? _____
Date of your last colonoscopy: _____

Family History:

Breast Cancer?	Yes____ No____	Who _____
Ovarian Cancer?	Yes____ No____	Who _____
Colon Cancer?	Yes____ No____	Who _____
Malignant Melanoma?	Yes____ No____	Who _____
Endometrial Cancer?	Yes____ No____	Who _____
Pancreatic Cancer?	Yes____ No____	Who _____

Please feel free to add any medical history of your own or your family that may not have been addressed above:
_____
_____
_____
_____