

Allergies

ALLERGY LIST	

Surgical History

Date	Surgery

Family History-please note if you family has had any of the following diseases

	Father	Mother	Sisters	Brothers	Sons	Daughters
Age, if living						
Deceased- specify age						
Hypertension						
Heart disease						
Stroke or TIAs						
Depression or mental health disorder						
Thyroid trouble						
Obesity						
Arthritis						
Suicide						
Heart attack						
Colon or Rectal Cancer						
Prostate Cancer						
Ovarian Cancer						
Melanoma						
Other Cancer						

Breast and Ovarian Risk Factors

	Breast Cancer before age 50	Breast Cancer at or after age 50	Breast Cancer at any age
Yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your Sister(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
Your Daughter(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
<i><u>Mother's side</u></i>			
Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aunt(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
Cousin(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
<i><u>Father's side</u></i>			
Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aunt(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
Cousin(s)	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>
<i><u>Father or Mother's side</u></i>			
Any males with breast cancer (at any age)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Social History

Number of people in your household: _____

Marital Status: Single Married Divorced Widowed

Tobacco: Non-smoker Former Smoker Current Smoker _____ packs per day

Caffeine: None Daily Coffee, tea, cola (circle all that apply) Cups per day _____

Alcohol:

Did you have a drink containing alcohol in the past year? _____

If yes, how often did you have a drink containing alcohol in the past year?

___ Never ___ Monthly or less ___ 2-4 times a month ___ 2-3 times a year ___ 4+ more a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more drinks

If yes, how often did you have 6 or more drinks on one occasion in the past year?

___ Never ___ Less than monthly ___ Monthly ___ Weekly ___ Daily or almost daily

OBGYN

Age of onset of periods: _____

Last menstrual period: ___/___/___

Age at menopause: _____

Number of pregnancies: _____ Age at first birth: _____

Number of live births: _____ Currently pregnant or breastfeeding? _____

History of breast biopsy: _____

Bra size: _____

Years on birth control: _____ Years on hormone replacement: _____

Ashkenazi Jewish? _____ History of radiation to chest? _____

Name: _____

Have you experienced any of the below recently?

General: (constitutional)

	<u>Yes</u>	<u>No</u>
Fatigue	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>

Cardiovascular:

Chest pain	<input type="radio"/>	<input type="radio"/>
Irregular heartbeats	<input type="radio"/>	<input type="radio"/>
Swelling in legs or ankles	<input type="radio"/>	<input type="radio"/>

Gastrointestinal:

Vomiting	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>

Hematology/Lymph:

Bleeding or bruising from minor injury	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>
Enlarged lymph nodes or gland swelling	<input type="radio"/>	<input type="radio"/>

Genitourinary:

Frequent urination	<input type="radio"/>	<input type="radio"/>
--------------------	-----------------------	-----------------------

Musculoskeletal:

Joint pain	<input type="radio"/>	<input type="radio"/>
Back pain	<input type="radio"/>	<input type="radio"/>
Muscle tenderness	<input type="radio"/>	<input type="radio"/>

Skin:

	<u>Yes</u>	<u>No</u>
Rash	<input type="radio"/>	<input type="radio"/>
Skin lesion(s)	<input type="radio"/>	<input type="radio"/>
Skin cancer	<input type="radio"/>	<input type="radio"/>

Neurologic:

Seizure disorder	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>

Psychiatric:

Anxiety	<input type="radio"/>	<input type="radio"/>
Depressed mood	<input type="radio"/>	<input type="radio"/>
Panic attacks	<input type="radio"/>	<input type="radio"/>

Respiratory:

Cough	<input type="radio"/>	<input type="radio"/>
Wheezing	<input type="radio"/>	<input type="radio"/>

Endocrine:

Cold intolerance	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>

Breast:

Pain	<input type="radio"/>	<input type="radio"/>
Rash	<input type="radio"/>	<input type="radio"/>
Nipple discharge	<input type="radio"/>	<input type="radio"/>
Lump	<input type="radio"/>	<input type="radio"/>