Breast Surgery Center of North Texas

Patient Name: _____ Date: _____

Instructions: Please check any of the following that apply to your RECENT health.

CONSTITUTION

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
  - How much? _____
  - Intentional? _____
- ☐ Malaise/Fatigue
- ☐ Diaphoresis (Sweating)
- ☐ Weakness

SKIN

- ☐ Rash
- ☐ Itching

HENT

- ☐ Headaches
- ☐ Hearing Loss
- ☐ Tinnitus (Ringing in ears)
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Stridor
- ☐ Sore Throat

EYES

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Photophobia (Light sensitivity)
- ☐ Eye Pain
- ☐ Eye Discharge
- ☐ Eye Redness

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Palpitations (Fast hear beat)
- ☐ Orthopnea (Shortness of breath when laying flat)
- ☐ Claudication (Calf pain w/walking)
- ☐ Leg Swelling
- ☐ PND (waking up w/shortness of breath)

RESPIRATORY

- ☐ Cough
- ☐ Hemoptysis (Coughing up blood)
- ☐ Sputum Production
- ☐ Shortness of Breath
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Heart Burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Melena (Black sticky stool)

GENITOURINARY

- ☐ Dysuria (Pain w/urination)
- ☐ Urgency
- ☐ Frequency
- ☐ Hematuria (Blood in urine)
- ☐ Flank Pain

MUSCULOSKELETAL

- ☐ Myalgias (Muscle pain)
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Falls

ENDO/HEME/ALLERGY

- ☐ Easy Bruise/Bleed
- ☐ Environmental Allergies
- ☐ Polydipsia (Excessive thirst)

NEUROLOGIC

- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory Change
- ☐ Speech Change
- ☐ Focal Weakness
- ☐ Seizures
- ☐ LOC (Passing out)

PSYCHIATRIC

- ☐ Depression
- ☐ Suicidal Ideas
- ☐ Substance Abuse
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Insomnia
- ☐ Memory Loss

*I have read all of the above and agree that all **UNMARKED** responses are symptoms that **DO NOT** apply to my recent health.*

Please sign: _____

Breast Surgery Center
of North Texas

Patient Name: _____

Primary care physician: _____

Reason for visit: _____

Referring physician: _____

Drug allergies? ☐ Yes ☐ No (If yes, please list all known drug allergies and reactions)

_____

_____

_____

Current medications and dosages: (Use back of page if more space is needed)

_____

_____

_____

Past medical history: (Please list all medical problems)

_____

_____

_____

_____

Surgical history: (Please list all surgeries and year it was done)

_____

_____

_____

_____

Family history: (Please list any and all family members with chronic medical problems)

_____

_____

_____

_____

Do you currently smoke? ☐ Yes ☐ No

If yes, check all that apply: ☐ Cigarettes ☐ Cigars ☐ Pipe

If yes, how many total years? _____ How many packs/day? _____

Are you a former smoker? ☐ Yes ☐ No

If yes, Date quit? _____ How many total years? _____ How many packs/day? _____

Have you ever used smokeless tobacco? ☐ Yes ☐ No

If yes, please specify: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks/day on average? _____ How many days/week? _____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, please specify: _____

Breast Surgery Center of North Texas

Patient Name: _____

Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No

If yes, please specify: _____

Are you of known Ashkenazi/Eastern European Jewish ancestry ☐ Yes ☐ No

If yes, please specify: _____

Age at first period? _____

Last menstrual period? (if applicable)_____

Age at menopause? (if applicable) _____

How many pregnancies have you had? _____

How many live births have you had? _____

Your age at first child's birth? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, how many?: _____

Did any of these show atypical cells? ☐ Yes ☐ No

If yes, please specify: _____

Current or prior birth control use? ☐ Yes ☐ No

If yes, total number of years used: _____

Current or prior hormone related therapy? ☐ Yes ☐ No

If yes, total number of years used: _____

Have you ever had radiation therapy to the chest or breast? ☐ Yes ☐ No

If yes, please specify: _____

Do you have **family history** of breast cancer? ☐ Yes ☐ No

If yes, please list relation to you and age at diagnosis: _____

Do you have **family history** of ovarian cancer? ☐ Yes ☐ No

If yes, please list relation to you and age at diagnosis: _____

When was your last mammogram? (Month/Year) _____ Location: _____