MEDICAL HISTORY -Breast Surgeon

1325 East Church Street, Suite 202, Santa Maria, CA 93454 PH (805) 346-3456 Fax (805) 346-3454

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

Medical Reason for visit _____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? YES NO

If yes, please list with reactions such as rash, swelling, hives, shortness of breath, ect

_____

_____

_____

Name of your current Pharmacy _____ Phone Number _____

Primary Care Doctor _____ Phone Number _____

Specialists Seen _____

PAST MEDICAL HISTORY

Did you have any unusual or serious childhood illnesses? If so, please list them:

_____

_____

Have you had any serious accidents that resulted in residual current problems? Such as falls, car accident, work related injuries, sports injuries, ect.

_____

_____

Have you ever received a blood transfusion and if yes, when and for what reason?

_____

_____

MEDICATION HISTORY

List all medications and vitamins that you are currently taking on a regular basis with the dose and frequency that you take. For example: asprin 81 mg once a day

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Do you or any one in your family have the following medical diseases?

You		Family	You		Family
_____	High Blood Pressure	_____	_____	Tuberculosis	_____
_____	Stroke	_____	_____	Emphysema	_____
_____	Heart Attack	_____	_____	Breast Cancer	_____
_____	Hepatitis	_____	_____	Kidney Disease	_____
_____	Mitral Valve Proiapse	_____	_____	Peptic Ulcer	_____
_____	Diabetes Type 1 or Type 2	_____	_____	Pneumonia	_____
_____	Bleeding Problems	_____	_____	Problems with Anesthesia	_____
_____	Clotting Problems	_____	_____	Cancer	_____
_____	Heart Disease	_____			

Mother	_____	Alive	_____	Age	_____	Died	_____ Age
Father	_____	Alive	_____	Age	_____	Died	_____ Age

SOCIAL HISTORY

_____	Married	_____	Single	_____	Widowed	_____	Divorced
_____	live alone	_____	live with family		_____	live with companion	

Do you have a "Living Will"?	YES	NO		
Do you have an "Advance Directive"?	YES	NO		
Did you ever smoke or do you still smoke?	YES	NO	_____	packs per day for _____ years
Do you drink alcohol?	YES	NO	_____	drinks per day/week
Do you excersise regularly?	YES	NO	_____	form of exercise

PAST SURGICAL HISTORY

Please list all previous surgeries and either the year they were done or your age at which they were done.

(Please include cosmetic surgery)

_____

_____

_____

_____

REVIEW OF SYMPTOMS: Mark all that apply

GENERAL

_____ Recent Weight loss/gain
_____ Headaches
_____ sinus problems
_____ nose bleeds

EYES

_____ Glasses
_____ contacts
_____ prior cataract surgery
_____ macular degeneration
vision problems

MOUTH

_____ false upper
_____ false lower
_____ bridges

NECK

_____ swelling
_____ pain

GI

_____ appetite
_____ swallowing
_____ nausea
_____ heartburn
_____ diarrhea
_____ constipation

LUNG

_____ wheezing
_____ shortness of breath
_____ cough
_____ sputum production

CARDIOVASCULAR

_____ chest pain
_____ ankle swelling
_____ leg cramps
_____ pacemaker
_____ palpitations
_____ varicose veins
_____ defibrillator

BREAST

_____ pain
_____ tenderness
_____ discharge
_____ lump
_____ redness

URINARY

_____ burning
_____ urgency
_____ blood in urine
_____ pain
_____ incontinence
_____ dribbling

MUSCULOSKELETAL

_____ arthritis
_____ weakness
_____ back ache
_____ neck ache

NEUROLOGICAL

_____ seizures
_____ tremors
_____ neuropathy

SKIN

_____ rash
_____ itching
_____ infection
_____ dryness

PSYCHIATRIC

_____ depression
_____ anxiety
_____ psychiatric disorder

HEMATOLOGIC

_____ bleeding
_____ clotting
_____ anticoagulant therapy

When was your last:

_____ Chest X-Ray

_____ Colonoscopy

Age you had your first menses (started your period) _____

How many times have you been pregnant? _____

How old were you when you had your first child? _____

How many children have you delivered? _____

How many abortions/miscarriages have you had? _____

Did you breast feed your children? _____

If yes, for how long? _____

Have you ever been on birth control pills and for how long? _____

Have you in the past or are you now taking Estrogen or Progesterone? _____

If yes, for how long? _____

Have you had previous breast biopsies? _____

If yes, which breast, when and what was the result? _____

Does anyone in your family have a history of breast cancer? _____

If yes, who, what age, and was it your mother's or father's side? _____

Deos anyone in your family have ovarian cancer? _____

If yes, who, what age, and was it your mother's or father's side? _____

Do any of the males in your family have breast cancer? _____

If yes, what age were they diagnosed? _____

Did any of the realtives with the breast cancer or ovarian cancer die of their disease? _____

If yes, at what age? _____

Do you have any Jewish descent in you or any of your family members? _____