TEXAS HEALTH CARE, P.L.L.C.
Breast Surgical Oncology

PATIENT HISTORY

label space

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Name _____ Today's Date _____
Date of Birth _____ Occupation _____
For what problem did you come to the doctor today? _____
_____
First noticed when _____ Location _____ Severity _____
Any associated symptoms _____
Doctor who sent you here _____ Family Doctor? ☐ OB/GYN? ☐
Are you allergic to anything? _____
Could you be pregnancy? _____ Date of last menstrual period _____
Medicines you take (include aspirin, over-the-counter, vitamin supplements):

Name of the medicine	Dosage	For what purpose?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Problems you have (Please check all that apply):

☐ Excessive Bleeding	☐ Heart Problems	☐ Arthritis	☐ Clotting or bleeding disorder
☐ Heart Attack (MI)	☐ Diabetes	☐ Sickle Cell Disease	☐ Heart Surgery
☐ Asthma	☐ Depression/Anxiety	☐ High Blood Pressure	☐ Stroke
☐ Autoimmune Disorder	☐ High Cholesterol	☐ Ulcer	☐ Kidney Problems
☐ Thyroid Disease	☐ TB	☐ HIV or AIDS	☐ Emphysema
☐ Anemia	☐ Hepatitis or Jaundice	☐ Cancer (What kind? _____)	

☐ Adverse reaction to Anesthesia (What reaction? _____)
Previous operations/surgery and dates _____

Removal of uterus? _____ Removal of ovaries? _____
Have you been hospitalized <u>not</u> involving surgery _____
_____
Do you smoke? _____ For how long? _____ How Much? _____
Serving per day: Coffee _____ Tea _____ Caffeinated drinks _____ Chocolate _____
Present alcohol use: _____ Past alcohol use: _____
Family History: Has anyone in your family had any of the following? If "yes" indicate that person's relation to you, otherwise, list "no":
High Blood Pressure _____ Heart attack _____
Heart Failure _____ Stroke _____
Diabetes _____ Anything that runs in the family _____
Cancer (who and what kind?) _____

<u>Breast Health Information</u>
Please list any previous breast problems OR breast surgery: _____
_____
_____
Family members with breast cancer? ☐ No ☐ Yes (if yes, please list approximate age below)
First degree relatives: _____ Sister(s) _____ Mother _____ Daughter(s) _____
Mother's side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____
Father's side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____

Age when menstrual periods began_____ How many children do you have? _____
How many times have you been pregnant?_____ Age at delivery of first live child _____
Have you ever taken birth control pills? _____ Approximate dates:_____
Have you ever taken hormones? _____ What kind? _____ Approximate dates_____
Do you now take hormones? _____ What kind? _____ Dose _____
How long have you taken it? _____

Review of Systems

Do you currently have any of these symptoms? (check all that apply)

CONSTITUTIONAL SYMPTOMS:
- ☐ Fever
- ☐ Infection
- ☐ Night sweats
- ☐ Fatigue
- ☐ Weight loss

Other general problems:

_____

EYES:
- ☐ Blindness
- ☐ Glaucoma
- ☐ Retinal problems
- ☐ Cataracts

Other eye problems:

_____

EARS, NOSE, MOUTH, AND THROAT:
- ☐ Earaches
- ☐ Ringing in the ear
- ☐ Sensation of spinning
- ☐ Nose bleed
- ☐ Sinus problems
- ☐ Sore tongue
- ☐ Dental problems
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Painful swallowing
- ☐ Difficulty swallowing
- ☐ Change in voice

Other head or neck problems:

_____

CARDIOVASCULAR:
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Ankle swelling
- ☐ Leg pain when walking
- ☐ Rheumatic fever
- ☐ Fast heart beats
- ☐ Irregular heart beats
- ☐ Heart murmur
- ☐ Congestive heart failure
- ☐ Myocardial infarction
- ☐ Pulmonary embolism
- ☐ Thrombophlebitis
- ☐ Venous or Arterial thrombosis

Other heart problems:

_____

RESPIRATORY:
- ☐ Chronic cough
- ☐ Coughing up blood

Other lung problems:

_____

GASTROINTESTINAL:
- ☐ Decreased appetite
- ☐ Difficulty swallowing
- ☐ Hiatal hernia
- ☐ Esophagitis
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Gastritis
- ☐ Liver disease
- ☐ Gallstones
- ☐ Crohn's disease
- ☐ Cirrhosis
- ☐ Ulcerative colitis
- ☐ Black stools
- ☐ Bloody stools
- ☐ Hemorrhoids
- ☐ Diverticulitis

Other stomach or intestinal problems:

_____

GENITOURINARY:
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Passing urine at night
- ☐ Kidney infection
- ☐ Bladder infection
- ☐ Enlarged prostate

GYNECOLOGY(women only):
- ☐ Uterine polyps
- ☐ Abnormal pap smear
- ☐ Endometriosis
- ☐ Abnormal vaginal bleeding

Last Gyn exam date:

_____

MUSCULOSKELETAL:
- ☐ Osteoporosis
- ☐ Artificial joints
- ☐ Disc problems

SKIN
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Previous biopsies
- ☐ Melanoma

Other skin problems:

_____

NEUROLOGICAL:
- ☐ Slurred speech
- ☐ Weakness on one side
- ☐ Seizures
- ☐ Migraines
- ☐ Temporary eye blindness
- ☐ Headaches

Other brain or nerve problems:

_____

PSYCHIARIC:
- ☐ Depression
- ☐ Drug/Alcohol Abuse

Other psychiatric problems:

_____

ENDOCRINES:
- ☐ Hypoglycemia
- ☐ Goiter/thyroid surgery
- ☐ Heat/cold intolerance

Other endocrine problems:

_____

HEMATOLOGIC/LYMPHATIC:
- ☐ Enlarged lymph nodes
- ☐ Hemophilia
- ☐ Easy bruising
- ☐ Blood clotting problems

Other blood or lymph node problems:

_____

Ethnicity: ☐ African-American ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Patient Signature _____ **Date** _____

Physician Signature _____ Date _____

Attending Physician Signature _____ Date _____