** *Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_  
  
Primary Care Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal for this visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** *(please list reaction such as swelling, hives, breathing problems)*  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History (Check all that apply)**⃝ Asthma ⃝ COPD ⃝ Sleep Apnea ⃝ Congestive Heart Failure  
  
⃝ Coronary Artery Disease ⃝ Hypertension ⃝ Hyperlipidemia ⃝ Myocardial Infarction  
  
⃝ Arthritis ⃝ Osteoporosis ⃝ Liver Disease ⃝ Heartburn/GERD  
  
⃝ Seizures ⃝ Stroke ⃝ TIA ⃝ Diabetes Mellitus  
  
⃝ Kidney Disease ⃝ Thyroid Disease ⃝ DVT/PE (Clotting Disorder)

Additional Medical Issues:   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal history of cancer?** If **YES,** **year diagnosed** \_\_\_\_\_\_\_\_\_\_ and please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment:** ⃝ Chemotherapy ⃝ Radiation ⃝ Surgery ⃝ Hormonal Therapy ⃝ None ⃝ Other

**Past Surgical History** *(please list all previous surgical procedures)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

**Marital Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol use:** ⃝ Never ⃝ Occasionally ⃝Monthly ⃝ Weekly ⃝ Daily

**Tobacco use:** ⃝ Never ⃝ Occasionally ⃝ Current everyday use ⃝ Quit\_\_\_\_\_\_

**What breast symptoms have you had? (Check all that apply)**

Breast Mass: ⃝ None ⃝ Right ⃝ Left ⃝ Both

Nipple Discharge: ⃝ None ⃝ Right ⃝ Left ⃝ Both

*If Yes, how often?* ⃝ *Rarely* ⃝ *Daily* ⃝ *Continuous*

Nipple Inversion: ⃝ None ⃝ Right ⃝ Left ⃝ Both

Erythematous (red) Breast: ⃝ None ⃝ Right ⃝ Left ⃝ Both

New Breast Pain: ⃝ None ⃝ Right ⃝ Left ⃝ Both

Chronic Breast Pain: ⃝ None ⃝ Right ⃝ Left ⃝ Both

*Severity of breast pain (circle)* 0 1 2 3 4 5 6 7 8 9 10

No Worst

pain pain ever

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_ Previous Breast Biopsy? ⃝ Yes (Date) \_\_\_\_\_\_\_\_ ⃝ No

**OB/Menstrual History**

Age at First Menstrual Cycle? \_\_\_\_\_\_\_\_\_

Present Menstrual Status? ⃝ Premenopausal ⃝ Removal of Ovaries ⃝ Menopausal

⃝ Post-Menopausal (AGE \_\_\_\_\_\_\_\_) ⃝ Uterine Ablation

Have you ever been pregnant? ⃝ Yes ⃝ No Age at first live birth? \_\_\_\_\_\_\_\_\_  
Did you breastfeed? ⃝ Yes ⃝ No How long? \_\_\_\_\_\_\_\_\_

**Birth Control Use: ⃝ Currently ⃝ Previously ⃝ Never Years Used?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hormone replacement use: ⃝ Currently ⃝ Previously ⃝ Never Years Used?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: ⃝ Estrogen Only ⃝ Progesterone Only ⃝ Estrogen/Progesterone

⃝ Patch or topical/vaginal creams

**Family History - Cancers**

Family includes *parents, children, siblings, grandparents, aunts, uncles, and cousins*

|  |  |  |
| --- | --- | --- |
| **Cancer Type** | **Family Member(s)** Please indicate Maternal or Paternal | **Age of Diagnosis** |
| Breast |  |  |
| Ovarian |  |  |
| Colon |  |  |
| Uterine |  |  |
| Melanoma |  |  |
| Pancreatic |  |  |
| Stomach |  |  |
| Prostate |  |  |
| Other |  |  |

**Are you of Ashkenazi Jewish Decent?** ⃝ Yes ⃝ No

**Any personal or family history of BRCA gene testing?** ⃝ Yes ⃝ No

If **YES**, who was tested and what was the result*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Current Medications** *(please include dose and reason for taking)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

**Constitutional**Appetite Change Yes No  
Fatigue Yes No  
Fever Yes No  
Weight Change Yes No

**Ear/Nose/Throat**  
Congestion Yes No  
Ear Pain Yes No  
Hearing Loss Yes No  
Mouth Sores Yes No  
Nosebleeds Yes No  
Sore Throat Yes No  
Ringing in Ears Yes No  
Trouble Swallowing Yes No  
  
**Respiratory**  
Chest Tightness Yes No  
Cough Yes No  
Shortness of Breath Yes No  
Wheezing Yes No

**Cardiovascular**  
Chest Pain Yes No  
Leg Swelling Yes No  
Palpitations Yes No  
  
**Gastroenterology**  
Abdominal Pain Yes No  
Blood in Stool Yes No  
Constipation Yes No  
Diarrhea Yes No  
Nausea Yes No  
Vomiting Yes No  
  
**Endocrinology**  
Cold Intolerance Yes No  
Heat Intolerance Yes No

**Urology**  
Difficulty Urinating Yes No  
Painful Urination Yes No  
Frequency Yes No  
Blood in Urine Yes No  
Urgency Yes No  
 **Musculoskeletal**  
Joint Pain Yes No  
Back Pain Yes No  
Difficulty Walking Yes No  
Joint Swelling Yes No  
Muscle Pain Yes No

**Dermatology**  
Color Change Yes No   
Rash Yes No  
Wound Yes No  
  
**Neurological**  
Dizziness Yes No  
Headaches Yes No  
Numbness Yes No  
Seizures Yes No  
Weakness Yes No  
  
**Hematology**  
Swollen Lymph Nodes Yes No  
Bruises/Bleeds Easily Yes No

**Psychiatric**  
Confusion Yes No  
Depression Yes No  
Nervous/Anxious Yes No  
Sleep Disturbance Yes No