

Patient Name: _____

Date of Birth: _____

Welcome to The Breast Center by Kansas Surgical Consultants. In order to provide the best care we need to know your medical history. Please take a few minutes to answer all questions. Please add any information you feel will help explain your health. If you need any help with this form please ask us. Thank you

Today's Date _____ Age _____ Height _____ Weight _____ Bra Size _____

Who referred you to our practice? _____

Have any of your family members been treated here? _____

Who is your Family Physician? _____

Please list any other doctors you wish us to communicate with? _____

BREAST HISTORY

Check the box if you have had:

- | | |
|---|---|
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Abnormal Mammogram |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> A Recent biopsy |
| <input type="checkbox"/> A breast mass you can feel | <input type="checkbox"/> Other _____ |

Check all that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Breast Cancer prior to age 50 | <input type="checkbox"/> Breast Cancer after age 50 | <input type="checkbox"/> Bilateral Breast Cancer |
| <input type="checkbox"/> Breast and Ovarian Cancer | <input type="checkbox"/> Ovarian Cancer at any age | <input type="checkbox"/> Male Breast Cancer any age |
| <input type="checkbox"/> Relative with BRCA mutation | <input type="checkbox"/> Strong family history of Breast/Ovarian Cancer | |
| <input type="checkbox"/> Pancreatic Cancer | <input type="checkbox"/> Ashkenaz/Eastern European Jewish Descent | |

MEDICAL CONDITIONS (adults only) (Review of Systems)

Have you had any of the following? If yes please check, if no problems check the no problems box.

General Health

- | | | |
|---|---|---|
| <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Recurrent fever | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> No Problems | |

Comments _____

Skin

- | | | |
|---|--|--|
| <input type="checkbox"/> Sores | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Non-Healing wound |
| <input type="checkbox"/> Changes in moles | <input type="checkbox"/> New lesions | <input type="checkbox"/> Burn Trauma |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Lumps/growths | <input type="checkbox"/> No problems |

Comments _____

Head, Ears, Eyes, Nose, Mouth, Throat

- | | | |
|---|---|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Eye infections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Blurred Vision |
| | | <input type="checkbox"/> No problems |

Comments _____

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Lung

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cough | <input type="checkbox"/> Sleep on more than 1 pillow |
| <input type="checkbox"/> Cough blood or mucus | <input type="checkbox"/> Wheezing | <input type="checkbox"/> No problems |

Comments _____

Breast

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Breast lump/mass | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Nipple pain | |
| <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Skin changes | |

Comments _____

Heart

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tightness | <input type="checkbox"/> Thumping or pounding |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Swollen arms or legs | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> No problems |

Comments _____

Stomach and Intestinal

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Special diet | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Positive hemoccult |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diverticulitis |
| | | <input type="checkbox"/> No problems |

Comments _____

Male Reproductive

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Frequency | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Urgency | <input type="checkbox"/> Testicular Pain |
| | | <input type="checkbox"/> No Problems |

Comments _____

Female Reproductive

- | | | |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Frequency | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Urgency | <input type="checkbox"/> No problems |

Comments _____

Muscle, Bone, Joint

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Muscle cramping |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Joint swelling | |

Comments _____

Nervous System

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Decreased memory | <input type="checkbox"/> Problem speaking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Problems moving |
| <input type="checkbox"/> Loss of consciousness | | <input type="checkbox"/> No problems |

Comments _____

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Veins (blood vessels), Lymphatic

- Abnormal bleeding Easy Bruising No problems
- Anemia Enlarged lymph nodes

Comments _____

ALLERGIES

Are you allergic to any medications, prescribed or over the counter? Yes No

If yes, please list medication and the reaction you had. (Include aspirin, Tylenol, vitamins, over the counter medications, herbal remedies, supplements etc.) _____

Are you allergic to any contacts such as latex, adhesive tape or betadine? Yes No

If yes, please list the contact and the reaction you had. _____

Are you allergic to any foods? Yes No

If yes, please list food and the reaction you had. _____

FAMILY HISTORY

Are there diseases or illnesses that family members have had? Please check the boxes below for any family member who has had the problem. **Under siblings please write brother or sister. Under Grandmother please write maternal (mother) or paternal (father). Under Grandfather please write maternal (mother) or paternal (father).**

	Mother	Father	Siblings	Grandmother	Grandfather	Children	Cousins	Aunt	Uncle
Anesthetic Problems									
Cancer -Breast									
Cancer -Colon									
Cancer-Ovarian									
Cancer-Pancreatic									
Cancer-Prostate									
Cancer-Other									
Diabetes									
Heart Disease									
High Blood Pressure									
Mental Illness									
Stroke									
Tuberculosis									

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WOMEN'S HISTORY

These questions help assess your individual risk for developing breast cancer:

Date or age of first menstrual period? _____

How old were you when you had your 1st child? N/A _____

Number of pregnancies? _____ Number of live births? _____

Have you reached menopause? Yes No If yes, at what age? _____

Date of last pap smear? _____ What were the results? _____

Do you do regular self breast exams? Yes No Date of last mammogram? _____

Have you ever had a breast biopsy? Yes No If yes, how many? _____

If yes, which breast? Right Left When date was this performed? _____

Were there any abnormal cells on the biopsy? Yes No If yes, please mark the following:

- Atypical Ductal Hyperplasia Breast grouped/clustered calcifications
- Lobular Carcinoma Insitu (LCIS)

Are you taking Hormone Replacement Therapy? Yes No If yes, how long? _____

Have you taken Hormone Replacement Therapy? Yes No If yes, when did you stop? _____

Have you or any family member been tested for a **BRCA** mutation? Yes No

How many of the woman's a first-degree relative have had breast cancer?

- Mother Sisters Daughters

PAST MEDICAL HISTORY

Please list any **SURGERIES** you have had and the year they were performed.

Have you ever had a **colonoscopy**? Yes No

If yes, please list the date and results. _____

Have you had any **serious injuries**? Yes No

If yes, please list the date and type of injury. _____

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Do you currently have any of the following medical problems?

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer, type _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis A B C Other |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Colitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Reflux | <input type="checkbox"/> Hyperthyroidism |
| | | <input type="checkbox"/> High Cholesterol | |

Please list any **other health problems** you have:

SOCIAL HISTORY

What is your marital status? Married Single Divorced Widowed

What is your occupation (if retired your past occupation)? _____

Do you smoke? Yes No If Yes, how much per day and how many years? _____

Have you ever smoked? Yes No If yes, what age did you quit?

Do you drink alcoholic drinks? Yes No If yes, how much and how often? _____

Do you take any drugs for reasons that are not medical? Yes No

If yes, please list _____

MEDICATIONS

List the **NAME** of medication, the **DOSE** of you medication, and **HOW OFTEN** you take the medication.

Please include and herbal medications or supplements

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Do you take blood thinners? Yes No

Do you take Metformin? Yes No

Do you take Aspirin daily? Yes No

Are you on a weight loss program? Yes No

Do you use a C-Pap machine? Yes No

Do you take Glucophage? Yes No

Do you take St. John's Wort? Yes No