New Patient Packet

DATE: _____

Patient Name: _____ **DOB:** _____
Referring Doctor: _____

Reason for appointment: _____

Allergies/contradictions and reaction type (Medications, dyes, latex, etc.)

_____
_____
_____

Current Medications
(Please list all prescription, over the counter, and herbal. Include dose strength)

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

Pharmacy Name: _____ **Address:** _____

Breast History:
Do you perform self-breast exams? _____
Do you get your mammogram annually? _____
Date of last mammogram: _____
Have you had a breast biopsy or procedure in the past? _____
_____
Are you currently being treated for breast cancer or have you been treated for breast cancer in the past?
_____

Gynecological History:
MENARCHE: _____ (AGE OF FIRST PERIOD) Age of Menopause: _____
Number of Pregnancies: _____ Number of live Births: _____ Age of delivery of first child: _____
Did you breastfeed? _____ How long did you breastfeed? _____
Bra Size? _____ Are you currently on Birth control? _____
Are you currently taking a hormone replacement therapy or have you in the past? _____
If yes, for how long? _____

Social History:
Occupation: _____ Marital status/support system: _____
Do you drink? _____ If yes how much? _____
Do you smoke? _____ Did you smoke? _____ Date Quit? _____
Do you have a chemical dependency? _____ Do you use recreational drugs? _____

Patient Name_____

List Prior Surgeries and dates:

_____
_____
_____
_____
_____

Personal Medical History:

Y N Alzheimer's disease
Y N Anemia
Y N Anesthesia Complications
Y N Angina
Y N Anxiety
Y N Arthritis
Y N Asthma
Y N Blood Clots (DVT/PE)
Y N Cancer
Y N Heart Failure
Y N Clotting Disorder
Y N COPD
Y N Coronary Artery Disease
Y N Crohn's Disease
Y N Depression
Y N Diabetes Mellitus
Y N Emphysema
Y N GERD
Y N Heart Failure
Y N Heart Murmur
Y N Heart Valve Disease
Y N Hepatitis/Liver Disease
Y N HIV/AIDS
Y N Radiation Treatment
Y N Hyperlipidemia
Y N Hypertension
Y N Inflammatory Bowel Dz
Y N Kidney Disease
Y N Myocardial Infarction
Y N Obesity
Y N Osteoporosis
Y N Osteopenia
Y N Other Skin Cancer
Y N Psychiatric Issues
Y N Pancreatitis
Y N Seizures
Y N Sickle Cell Anemia
Y N Sleep Apnea
Y N Stroke
Y N TB
Y N Thyroid Disease
Y N Ulcerative Colitis
Y N Any metal in your body

Other Medical Problems:

_____
_____
_____
_____

What is the name of your cardiologist, neurologist, pulmonologist or any other specialist you are seeing? _____
_____

Family Medical History:
(Please indicate if relative is alive or deceased, any medical problems)
Mother:_____
Father: _____
Siblings:_____
Children:_____
Maternal Grandparents**:**_____
Paternal Grandparents:_____
Any family history of Breast or Ovarian Cancer and age of diagnosis:_____
_____

Patient Name: _____

Please circle any symptoms you are currently experiencing:

GENERAL
Y N Activity change
Y N Appetite change
Y N Chills/Sweating
Y N Fatigue
Y N Fever
Y N Weight change

ENDOCRINE
Y N Cold intolerance
Y N Heat intolerance
Y N Excessive thirst
Y N Excessive urination

ALLERGY/IMMUNO
Y N Environmental allergies
Y N Food allergies
Y N Immunocompromised

HEME/LYMPH
Y N Adenopathy
Y N Bruises/Bleed easily

PSYCH
Y N Agitation
Y N Behavioral problems
Y N Confusion
Y N Decreased concentration
Y N Hallucinations
Y N Self injury
Y N Sleep disturbance
Y N Suicidal thoughts

HEAD/NECK
Y N Congestion
Y N Dental problems
Y N Hearing loss
Y N Mouth sores
Y N Nose bleeds
Y N Sore throat
Y N Trouble swallowing
Y N Voice change

EYES
Y N Eye redness
Y N light sensitivity
Y N visual disturbance

NEURO
Y N Dizziness
Y N Facial asymmetry
Y N Headaches
Y N Lightheaded
Y N Numbness
Y N Seizures
Y N Speech difficulty
Y N Fainting
Y N Weakness

RESPIRATIORY
Y N Chest tightness
Y N Cough
Y N Shortness of breath
Y N Wheezing

CARDIOVASCULAR
Y N Chest pain
Y N Leg swelling
Y N Palpitations

SKIN
Y N Hair change
Y N Rash
Y N Wound healing issues

MUSCULOSKELETAL
Y N Joint pain
Y N Back pain
Y N Gait problems
Y N Joint swelling
Y N Muscle pain
Y N Neck pain/stiffness

BREAST
Y N Breast mass
Y N Skin changes
Y N nipple discharge

GI
Y N Abdominal pain
Y N Blood in stool
Y N Constipation
Y N Diarrhea
Y N Nausea
Y N Vomiting

GU
Y N Difficulty urinating
Y N Painful urination
Y N Inability to urinate
Y N Blood in urine
Y N Pelvic pain
Y N Urgency
Y N Decreased urine