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:

- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ A breast mass you can feel
- ☐ Abnormal Mammogram
- ☐ A Recent biopsy
- ☐ Other_____

Check all that apply to you:

- ☐ Breast Cancer prior to age 50
- ☐ Breast Cancer after age 50
- ☐ Bilateral Breast Cancer
- ☐ Breast and Ovarian Cancer
- ☐ Ovarian Cancer at any age
- ☐ Male Breast Cancer any age
- ☐ Relative with BRCA mutation
- ☐ Strong family history of Breast/Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ 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

- ☐ Recurrent infections
- ☐ Recurrent fever
- ☐ Fatigue
- ☐ Night sweats
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Decreased appetite
- ☐ No Problems

Comments _____

Skin

- ☐ Sores
- ☐ Hair Loss
- ☐ Non-Healing wound
- ☐ Changes in moles
- ☐ New lesions
- ☐ Burn Trauma
- ☐ Rash
- ☐ Lumps/growths
- ☐ No problems

Comments _____

Head, Ears, Eyes, Nose, Mouth, Throat

- ☐ Ear infections
- ☐ Nose bleeding
- ☐ Cataracts
- ☐ Sore throat
- ☐ Seasonal allergies
- ☐ Eye infections
- ☐ Headaches
- ☐ Corrective Lenses
- ☐ Blurred Vision
- ☐ No problems

Comments _____

Patient Name: _____ **Date of Birth:**_____

Lung

☐ Difficulty breathing ☐ Cough ☐ Sleep on more than 1 pillow
☐ Cough blood or mucus ☐ Wheezing ☐ No problems
Comments_____

Breast

☐ Breast lump/mass ☐ Nipple discharge ☐ No problems
☐ Breast pain ☐ Nipple pain
☐ Breast swelling ☐ Skin changes
Comments_____

Heart

☐ Chest pain ☐ Tightness ☐ Thumping or pounding
☐ Heart murmur ☐ Swollen arms or legs ☐ Shortness of breath
☐ Rheumatic fever ☐ High blood pressure ☐ No problems
Comments_____

Stomach and Intestinal

☐ Special diet ☐ Heartburn ☐ Rectal Bleeding
☐ Nausea ☐ Indigestion ☐ Blood in stool
☐ Vomiting ☐ Black Stools ☐ Positive hemoccult
☐ Ulcers ☐ Constipation ☐ Diverticulosis
☐ Difficulty swallowing ☐ Diarrhea ☐ Diverticulitis
☐ No problems
Comments_____

Male Reproductive

☐ Painful Urination ☐ Frequency ☐ Impotence
☐ Prostate problems ☐ Urgency ☐ Testicular Pain
☐ No Problems
Comments_____

Female Reproductive

☐ Painful urination ☐ Frequency ☐ Blood Clots
☐ Irregular Periods ☐ Urgency ☐ No problems
Comments _____

Muscle, Bone, Joint

☐ Joint Pain ☐ Neck Pain ☐ Muscle cramping
☐ Muscle Pain ☐ Joint stiffness ☐ No problems
☐ Back pain ☐ Joint swelling
Comments_____

Nervous System

☐ Seizures ☐ Decreased memory ☐ Problem speaking
☐ Dizziness ☐ Fainting ☐ Problems moving
☐ Loss of consciousness ☐ No problems
Comments_____

Patient Name: _____ Date of Birth:_____

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									

Comments _____

Patient Name: _____ Date of Birth:_____

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. _____

Patient Name: _____ Date of Birth:_____

Do you currently have any of the following medical problems?

□ Heart Disease	□ Ulcers	□ Depression	□ Cancer, type_____
□ Diabetes	□ Epilepsy	□ Kidney Disease	□ Hepatitis A B C Other
□ High Blood Pressure	□ HIV	□ Jaundice	□ Pneumonia
□ Stroke	□ Anemia	□ Lung Disease	□ Hypothyroidism
□ Cataracts	□ Colitis	□ Glaucoma	□ Headaches
□ AIDS	□ Leukemia	□ Reflux	□ Hyperthyroidism
		□ 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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth:_____

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