Patient History Questionnaire
Comprehensive Breast Care Center

Patient Name		Date of birth	Age
Occupation		Today's Date	
Height	Weight		

Primary Care Physician:
OB/ GYN:
Referring Physician:
Who else may we send a medical consult letter to? Please indicate here:

HISTORY OF PRESENT ILLNESS

What is the reason for today's visit? ____
____

Please check all that that apply:

- I feel a lump in my breast?

  If yes, which breast? Right Left

  If yes, present for how long? ______________________

  Is the lump painful? Yes No

  Does the lump change in size with your periods? Yes No
- I have had a Mammogram in the past

  Mammogram was performed at ___________________.

  Approximate date of most recent mammogram___________________.
- I have been told I've had an abnormal mammogram.
- Other breast problems include ____

PERSONAL BREAST HISTORY:

Have you ever had:

Breast cancer? _________ If so, when ______________ Which breast? ______________

How was it treated? ____

A breast biopsy? ______________ If so, when _________ Which breast? _____________

Injury to your breasts? _______________________ If so, when _____________________
A needle aspiration to remove fluid from a cyst? __________ Which breast?_________

Nipple discharge? ____________ If so, when______________ Which breast?________

PATIENT NAME ________________________________ TODAY'S DATE ____________________

HORMONAL HISTORY:

If menstruating, date of your last period (first day of): ____

Your age when you began your periods ________ Age when you stopped (if you have) _____________

Have you had a hysterectomy? _______ If so at what age? ______ and for what reason _____________

Do you still have your ovaries? ____________

How many times have you been pregnant? __________ How many children do you have? _____________

How old were you when your first child was born? _____________ Are you pregnant now?_____________

Have you ever taken Hormone Replacement Therapy? _____________ If so, when and for how long?_____

FAMILY HISTORY (please list all relatives who have had breast cancer)

Relative	Mother's or Father's side	Age at diagnosis	One or both breasts	If living, age	If deceased, age at death

Please list other cancers in your family (colon, ovarian, uterine, lung, etc), who had cancer, and at what age it Was diagnosed:

Relative	Mother's or Father's side	Site of cancer	Age at diagnosis

PAST AND CURRENT MEDICAL PROBLEMS:

1.____

2.____

3.____

4.____

5.____

6.____

7.____

PATIENT NAME _________________________________ **TODAY'S DATE** ____________________

HOSPITAL ADMISSIONS OR SURGERIES (please list):

Date	Illness or operation

CURRENT MEDICATIONS, DOSAGES, FREQUENCY AND REASON **(include over the counter & herbals)**

Medication	Dose	Frequency	Reason to take

ALLERGIES :(to medications):

MEDICATION	What happens?

Other substances

____________________ ____

____________________ ____

PATIENT NAME ________________________________ **TODAY'S DATE** ____________________

SOCIAL HISTORY:

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you exercise? ☐ Yes ☐ No Type of exercise: ________________

Times per Week: ______________

Do you smoke ☐ Yes ☐ No Numbers of cigarettes per day _____________________

Did you smoke? ☐ Yes ☐ No Packs per day ___________ how many years? _____________

What year did you quit? ___________

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week _________________

Do you ever feel you are physically or emotionally threatened by any person? ☐ Yes ☐ No

Do you have any difficulties performing your normal activities of daily living? ☐ Yes ☐ No

Current pain: ☐ No ☐ Yes Severity Scale: 1 2 3 4 5 6 7 8 9 10 (circle)

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

Constitutional:	☐ Unexplained Weight Loss/gain	☐ Appetite loss	☐ Unexplained fever/ chills
	☐ Fatigue	☐ Dizziness	☐ Other __________
Eyes:	☐ Vision problems	☐ Frequent headaches	☐ Other __________
Ears / Nose / Throat	☐ Hearing problems	☐ Ringing in the ears	☐ Bloody nose
	☐ Other __________		
Cardiovascular:	☐ Chest pain	☐ High cholesterol	☐ Swelling
	☐ Loss of consciousness	☐ Pacemaker	☐ Other __________
Gastrointestinal:	☐ Indigestion	☐ Heartburn	☐ Nausea / vomiting
	☐ Abdominal Pain	☐ Constipation	☐ Diarrhea
	☐ Bloody Stools	☐ Other __________	
Genitourinary:	☐ Difficult urination	☐ Frequent urination	☐ Bloody urine
	☐ Frequent nighttime urination	☐ Discharge	☐ Uterine fibroids
	☐ Endometriosis	☐ Ovarian cysts	☐ Other __________
Musculoskeletal:	☐ Painful joints	☐ Back pain	☐ Difficulty in performing normal activities
	☐ Other ___________		
Integument / Skin:	☐ Rashes	☐ Hives	☐ Other___________

Neurologic:	☐ Seizures ☐ Other____________	☐ Speech problems	☐ Tingling of extremities
Respiratory:	☐ Shortness of breath Other___________	☐ wheezing	☐ Cough

PATIENT NAME ________________________________ **TODAY'S DATE** ____________________

Psychiatric:	☐ Depression ☐ Other	☐ Anxiety	☐ High stress
Endocrine:	☐ Breast Masses ☐ Other___________	☐ High blood sugar	☐ Steroid use
Hematologic:	☐ Bruise easily ☐ Other___________	☐ Anemia	☐ Bleeding disorder
Allergies:	☐ Seasonal Allergies	☐ Other__________	

Patient signature/ or person completing these forms _____________________________________

Today's Date: ___________________________________

I have reviewed the patient history questionnaire.

______________________ Physician signature	______________ Date	☐ No change in HX
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______________________ Physician signature	______________ Date	☐ No change in HX
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Physician signature Date

_______________________________ _______________________________ ☐ No change in HX

Physician signature Date