Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

Name:	**Age:**	**Date:**

1. What is the reason for your visit?

____

____

____

2. Present Health Concerns:

____

____

____

3. Breast Disease:

____

____

____

4. Past Medical History (*Check all boxes that apply*)

Check the box under "YES" column if you have had any of the following medical problems in the past:

Your Personal Medical History

MAJOR ILLNESSES	YES	MAJOR ILLNESSES	YES
Alcoholism		Heart Murmur	
Anemia		Hepatitis/Jaundice	
Anxiety		High Blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Kidney Infections	
Blood Clot/DVT		Kidney Stones	
Blood Transfusions		Migraines	
Bowel Trouble		Mood Disorders	
Breast Cancer		Osteopenia	
Cancer – List type below:		Osteoporosis	
		Ovarian Cancer	
Chronic Lung Disease		Pneumonia	
Depression/Suicide Attempt		Rheumatic Fever	
Diabetes		Sexually Transmitted Diseases	
Fracture		Stroke	
GERD		Tuberculosis – TB	
Glaucoma		Thyroid Disease	
Heart Disease		Ulcers	

OTHER: Where you have indicated **"YES"** please provide details below, or additional medical problems:

____

____

____

____

____

NAME:	DOB:

5. Past Surgical History

Year	Operation

6. Allergies (Drugs, Food, Environmental)	Reactions

7. Current Medications: Prescriptions and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage	Frequency	Date prescribed	By who?

8. Family History: (Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column **AND THE AGE OF ONSET.**

	None	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Arthritis											
Blood Clots											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Elevated Cholesterol											
Endometriosis											
Heart Disease											
Hypertension											
Melanoma											
Ovarian Cancer											
Pancreatic Cancer											
Stroke											
Thyroid Disease											
Other cancer not mentioned:											
Other disease not mentioned:											

NAME:		DOB:	
9. Social History			
Occupation	What is your occupation?		
Marital Status	□ Married □ Domestic Partner □ Divorced □ Re-married □ Separated □ Single □ Widowed		
Alcohol Use	□ No □Yes	Drinks per week:______	Is alcohol use a concern for you or others? □ No □Yes
Drug Use	Do you use recreational drugs? □No □Yes	Have you ever used needles? □ No □Yes	
Tobacco Use	Cigarettes: □ Never □ Quit: Date:__________ □ Current Smoker, packs per day___________ Number of years:_________ □ Former Smoker, packs per day___________ Number of years:_________ Other Tobacco: _________________ Are you interested in quitting? □ No □ Yes		

10. Review of Body Systems *(Check all that are applicable and explain if needed)*	
Constitutional	□ Chills □ Excessive urination □ Fever □ Weight gain □ Excessive thirst □ Fatigue □ Night sweats □ Weight loss
Eyes	□ Recent changes in vision □Left □Right □ Both
HENT (Head, ears, nose and throat)	□Hay fever or allergies □ Problems with teeth or gums □ Sinus pain/congestion
(Breasts)	□ Changes in skin □ Discharge □Lumps □ Pain
Cardiovascular	□ Chest pain □Palpitations
Respiratory	□ Cough □ Shortness of Breath □ Wheezing
Gastrointestinal	□ Abdominal pain □ Blood in stools □ Diarrhea □ Bloating □ Constipation □ Nausea □ Vomiting
Genitourinary/Gynecological	□ Frequency □ Incontinence □Sexual dysfunction □ Urinary retention □ Blood in urine □ Pain with urination □Urgency □Vaginal discharge
Integument	□Changes to existing skin lesions or moles □ Rash
Neurological	□ Dizziness/lightheaded □ Headaches □ Convulsions □ Numbness
Psychiatric	□ Anxiety □ Depression □ Difficulty sleeping
Hematologic-Lymphatic	□ Bleeding disorder □ unexplained lumps □Blood clots
Musculoskeletal	□ Joint Pain □Muscle Aches □ Back pain
Others not mentioned above	