breastlink of NEW YORK

Addendum to Medical Summary

Name:_____Date of Birth:_____Age:_____

Gender: Male ☐ Female ☐ Height:_____Weight:_____Blood Type (If Known): _____

Reason for Consultation: _____

Referring Physician: _____

Medications:

Please list all medications with strengths and doses; and frequency, include prescription and over the counter medications, including aspirin, Motrin and Advil.

Medication Name: Dosage:

_____

_____

_____

_____

Herbal / Natural Supplement: Dosage:

_____

_____

Gynecologic History:

What age did your periods start?_____What age did your periods stop or currently premenopausal? _____

How many times have you been pregnant?_____How many live births have you had? _____

What age were you at your 1st live birth?_____Are you currently pregnant? _____

Have you ever used birth control pills? Yes ☐ No ☐ If so, for how many years? _____

Have you ever used any hormone replacements? Yes ☐ No ☐ If so, for how many years? _____

Have you ever been involved in any fertility treatments? Yes ☐ No ☐ Clomid ☐ Injectable ☐

If so, how many cycles: _____

Have you ever had a breast biopsy? Yes ☐ No ☐ If yes, were the cells ever found to be atypical, premalignant or abnormal in any way? Yes ☐ No ☐

Are you a current tobacco user?

☐ Never

☐ Yes How many packs per day?_____For how long? _____

☐ Quit How long ago?_____How many packs did you smoke per day?_____For how long? _____

What is your current alcohol intake?

☐ Never ☐ Socially, 1 – 3 drinks per week ☐ Daily Mild Consumption, 1 drink daily

☐ Daily Moderate Consumption, 2 – 3 drinks daily ☐ Daily Large Consumption, 3 or drinks daily

☐ History of Alcoholism ☐ Other _____