breastlink of NEW YORK

New Patient Medical Questionnaire

Patient Name: ______________________________ Date of Birth: _____________ Date: _______________

Primary Care Physician _______________________ Referring Physician: ____________________________

Reason for Visit: □ Abnormal Mammo □ Lump □ Pain □ Nipple discharge □ Other ___________________

Most Recent Mammogram: Date: ___________ Place: _________________ Results: □ Normal □ Abnormal

Other Breast Imaging: Date: ___________ Place: _________________ Results: □ Normal □ Abnormal

FAMILY HISTORY

Breast Cancer □ Yes □No **If yes who and at what age** ____

Ovarian Cancer □ Yes □No **If yes who and at what age** ____

Other Cancer- who and what kind? ____

Other Illness: ____

Ethnicity/Ethnicities: ____

Previous Breast Surgery

History of Breast Cancer □ Yes □No If yes, explain: ____

Other Breast Problems □ Yes □No If yes, explain: ____

____

Previous Plastic Surgery □ Breast Augmentation □Breast Reduction □ Mastopexy □ Other ____________

Implants: Date of placement: ______________________________ Type: ______________________________

History of Other Surgeries (and dates) :

____

____

Past Medical History: Please check all problems that you may have/had:

□Anemia
□Arthritis
□Asthma
□Autoimmune disorder
□Clotting/ Bleeding disorder
□Depression
□Diabetes
□Emphysema
□Excessive Bleeding
□Gastrointestinal disorders
□Heart Attack
□Heart Problems
□Heart Surgery
□Hepatitis/Jaundice
□High Blood Pressure
□High Cholesterol
□Kidney Problems
□Thyroid
□TB
□Cancer-what kind?
____

ALLERGIES: Medications: □ Yes □No Food Allergies: □ Yes □No Latex Allergies: □ Yes □No

If yes, please list: ____

MEDICATION LIST:

_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________

Patient Name: ____ Date of Birth: _________________________

OBSTETRICAL/GYNECOLOGICAL HISTORY:

Age at menses: ________ Last menstrual period: _____________

# of pregnancies: _______ # of miscarriages/abortions______

Age at first live birth : _________ Breast feeding history: □Yes □No Age at menopause __________

Birth Control Pill:

□ Yes Number of years taken _________ □ Never

□ Previously taken How many years taken _________ No. of years since last taken ____

Hormone Replacement :

□ Yes Number of years taken _________ □ Never

□ Previously taken How many years taken _________ No. of years since last taken ____

SOCIAL HISTORY:

Marital Status □ Single □ Married □ Widowed □ Divorced

Alcohol □ Denies □ Current: _________drinks per day/ week/ month

Tobacco □ Denies □ Current: _________ packs/day □Past _____ packs/day Year Quit ________

Illicit Drugs □ Denies □ Current Substances: ________________ □ Past Substances ________

Caffeine: □ Denies Cups/Day ________________

Height: _______________ Weight: ____________

REVIEW OF SYSTEMS: Have you recently had any of the following: (please check (√) if yes)

General: □Weight loss (how much) ________ □Weight Gain (how much)________

Skin: □ Skin Problems □ Skin Cancers □Psoriasis □ Other ______________________

HEENT: □ Visual Problems □ Hearing Problems □ Nose/Throat Infections □ Other ____________

Pulmonary: □ Shortness of breath □ chronic cough □ Other _______________________

Cardiovascular: □ Irregular Heartbeat/Arrhythmia □ History of Heart Attack

□ Past Cardiac Surgery □ Other _______________

Peripheral Vascular: □ History of leg cramping with walking □ Other ______________________

Gastrointestinal: □ Acid Reflux □ Abdominal Pain □ change in bowel habits

□ blood in stool □ Other ___________________

Genitourinary: □ History of blood in urine □ Incontinence □ Other ___________________

Endocrine: □ History of thyroid problems □ Diabetes □ Other ___________________

Hematology/Immune: □ Anemia □ Bleeding Problems □ Auto Immune Disorders □ Other ___________________

Musculoskeletal: □ Chronic Back Pain □ Neck Pain □Other _______________________________

Neurological/Psych: □ Depression □ Anxiety □ Neurological Disorder __________________

□ Other _______________________

Signature ____ **Date** _______________