Document Type: Forms/Other

MSC077

METHODIST

Breast Health

Name: _____ Today's Date:_____
Referring M.D. _____ Age: _____ Date of Birth:_____
Primary Care Physician: _____
Present Complaint:_____
(lump, pain, nipple discharge, abnormal mammogram, etc.)
Email Address: _____

PERSONAL HISTORY

Age at First Menstrual Period: _____ Date of Last Period: _____
Period Regularity: _____
Age at Menopause: _____ ☐ Natural ☐ Surgical Hysterectomy / Oophorectomy
Have you ever taken oral contraceptives? ☐ Yes ☐ No Type:_____ # of Years: _____
Progesterone, Estrogen, Fertility Txs or other hormone therapy? ☐ Yes, current ☐ Yes, in past ☐ No, never
Current Bra Size:_____ If yes, Type:_____ # of Years: _____
Breast Enlargement: ☐ Yes ☐ No When:_____
Breast Reduction: ☐ Yes ☐ No When:_____
Age at First Live Birth: _____ Number of: Pregnancies _____ Full-term Pregnancies _____ Miscarriages ____
Did you Breast Feed? ☐ Yes ☐ No How long?_____
Previous Mammogram: ☐ Yes ☐ No If Yes, When?_____ Where?_____
Previous Breast Procedures:_____
(lumpectomy, mastectomy, implants)
Date _____ ☐ R ☐ L ☐ B Where:_____

Personal history of breast cancer? ☐ Yes ☐ No Age at Diagnosis: _____
Year of Diagnosis: _____ Treatments:_____
Surgery: ☐ Mastectomy ☐ Lumpectomy ☐ Breast: ☐ R ☐ L ☐ Bilateral
☐ Reconstruction: ☐ Yes ☐ No Type:_____
Dr. _____ Date:_____
Personal history of ovarian cancer? ☐ Yes ☐ No Age at Diagnosis: _____
Year of Diagnosis: _____ Treatments:_____
Dr. _____ Date:_____
Treatment: ☐ Chemotherapy ☐ Radiation ☐ Hormonal ☐ None
Dr. _____ Dr. _____ Dr. _____
History of recurrence: ☐ Yes ☐ No Date: _____

FAMILY HISTORY OF CANCER

M = Maternal P = Paternal
Breast Cancer and Age of Diagnosis: Mother_____, Sister_____,
Aunt_____, Grandmother_____, Cousin_____, Other_____
Other Family History of Cancer: _____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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METHODIST

SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widowed Race:_____

Children: ☐ Yes ☐ No How many?_____

Occupation: _____ Employed or Retired?_____

Alcohol use: ☐ Yes ☐ No How much:_____ (including beer and wine)

Tobacco use: ☐ Yes ☐ No Type: _____ (including vaping)

Caffeine use: ☐ Yes ☐ No How much:_____ (coffee, tea, cola, chocolate, medication)

Drug use: ☐ Yes ☐ No How much:_____ (marijuana, LSD, speed, heroin, others)

Any financial concerns related to your breast care? ☐ Yes ☐ No

CURRENT MEDICATIONS:

Pharmacy:_____

_____ _____

_____ _____

_____ _____

Are you taking blood thinners? (Coumadin, aspirin products) ☐ Yes ☐ No What?_____

Have you taken any steroids in the last 6 months? ☐ Yes ☐ No

ALLERGIES:

Latex Sensitivity? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, what?_____

What type of reaction?_____ Any other allergies?_____

REVIEW OF SYSTEMS / PAST MEDICAL HISTORY (mark all that apply)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Trouble Sleeping

HEAD
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Sinus Problems
- ☐ Hearing Problems
- ☐ Eye Problems

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Arrhythmia
- ☐ Chest Pain
- ☐ Rheumatic Fever

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma/Hay Fever
- ☐ Emphysema/COPD
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Pneumonia

GASTROINTESTINAL
- ☐ Nausea/Vomiting
- ☐ Constipation/Diarrhea
- ☐ Stomach Pain
- ☐ Trouble Swallowing
- ☐ Chage in Bowel habits
- ☐ Appetite loss
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Colitis
- ☐ Hiatal Hernia
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Black stools

GENITOURINARY
- ☐ Pain/burn on urination
- ☐ Blood in urine
- ☐ Loss Bladder control
- ☐ Trouble start/stop
- ☐ Kidney Disease
- ☐ Kidney stones
- ☐ Kidney problems
- ☐ Ulterine prolapse

MUSCULOSKELETAL
- ☐ Leg pains
- ☐ Joint pains
- ☐ Back pain
- ☐ Ankle swelling
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Restricted movement
- ☐ Ankylosing spondylitis
- ☐ Fibromyalgia

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disease

SKIN
- ☐ Hair Loss
- ☐ Rash

NEUROLOGIC
- ☐ Headache
- ☐ Stroke
- ☐ Seizures
- ☐ Dizziness
- ☐ Blackout/Fainting
- ☐ Weakness arms/legs
- ☐ Neurological disease

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Chemical Dependency
- ☐ Eating disorder
- ☐ Schizophrenia
- ☐ Treatment by psychiatrist or psychologist

HEMATOLOGY ONCOLOGY
- ☐ Cancer
- ☐ HIV
- ☐ Anemia
- ☐ Clotting
- ☐ Bleeding
- ☐ Phlebitis
- ☐ Blood disease

AUTOIMMUNE
- ☐ Systemic lupus erthematosis
- ☐ Scleroderma
- ☐ Dermatomyositis
- ☐ Collagen vascular disease

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