Document Type: Forms/Other
Subject: Breast Center - Health History

*MSC123*

METHODIST

# Breast Care Center Health History Form

☐ Methodist Hospital ☐ Methodist Jennie Edmundson Hospital

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: _____

## 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
☐ Change 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
☐ Uterine 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 erythematosus
☐ Scleroderma
☐ Dermatomyositis
☐ Collagen vascular disease

## SURGERIES AND HOSPITALIZATIONS

_____ _____
_____ _____
_____ _____

**ALLERGIES:** Latex Sensitivity? ☐ Yes ☐ No
Are you allergic to any medications? ☐ Yes ☐ No If yes, what?_____
What type of reaction?_____ Any other allergies?_____

**CURRENT MEDICATIONS/SUPPLEMENTS:** Height: _____ Weight: _____

_____ _____
_____ _____
_____ _____

Are you taking blood thinners? (Coumadin, aspirin products) ☐ Yes ☐ No What?_____
Have you taken any steroids in the last 6 months? ☐ Yes ☐ No
History of DVT/PE? ☐ Yes ☐ No History of Blood Transfusions? ☐ Yes ☐ No

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____

**PERMANENT PART OF MEDICAL RECORD**