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MSC077

Breast Care Center
Health History

METHODIST

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