General Surgery of Trinity

Breast Health History

Alene J. Wright, MD FACS

Today's Date________________

Patient Name________________________________ D.O.B. ___________

Family History of Precancerous or Cancerous Breast or Ovarian Disease:

Family Member	*Diagnosis/Problem*	*Age at Diagnosis*
____________	________________________	_______
____________	________________________	_______
____________	________________________	_______
____________	________________________	_______

Personal Surgical Breast History (Including any biopsies, needle or open):

Breast Procedure	*L/R*	*Year*	*Results*
_____________________	____	____	___________________________
_____________________	____	____	___________________________
_____________________	____	____	___________________________
_____________________	____	____	___________________________

Gynecological History:

Age at First Period	*Age at First Live Birth*	*Age at Menopause*
______	______	______

Surgical GYN Procedures	*Age*	*(If had a Hysterectomy, were ovaries removed?)*
_____________________	_____	*Circle one (Yes/No)*
_____________________	_____	

*Years of hormonal based Birth control used:*_______ *Still Taking? Y/N*

*Years of Hormone replacement:*________ *Still Taking? Y/N*

Genetic Testing for BRAC 1 and 2: *Date Testing Performed:*___________________

*Results if known:*__________________________

General Surgery of Trinity

New Patient Information

Patient____ Date of Birth___________________________ Date_____________

Referring Doctor__________________Family Doctor________________SS#_________________________Age__________

Reason for Visit:____

____

____

Past Surgery: Have you had any of the following operations and the year:

☐ Appendix________year ☐ Gall Bladder______year ☐ Thyroid______year ☐ Hysterectomy______year

☐ Hernia________year ☐ Heart______year ☐ Lung______year ☐ Spine/joint______year

☐ Tonsils_______year Other (Please describe)____

____

PATIENT SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously,but quit

Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Current ____________Packs a Day

Use of Drugs: Type__________________________ Frequency_________________________

FAMILY MEDICAL HISTORY

	AGE	DISEASE	DECEASED/CAUSE OF DEATH
Mother			
Father			
Sibling (1)		Male or Female	
Sibling (2)		Male or Female	
Sibling (3)		Male or Female	
Sibling (4)		Male or Female	

Current Medications and dosages of each (include herbal supplements, vitamins and Aspirin):_______________________

____

____

____

____

____

List Allergies to medication and their reaction:____

____

____

____

____

____

____ ___________________________

Signature Date

General Surgery of Trinity

HEALTH HISTORY

Name:____Birth date:________________

Today's Date:____________________________ Date of last physical examination:__________________

GENERAL
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Loss of Weight
- ☐ Numbness
- ☐ Sweats

EYE, EAR, NOSE,THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling ankles

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Decrease in exercise capacity

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation or diarrhea
- ☐ Gas
- ☐ Heartburn or Indigestion
- ☐ Hemorrhoids
- ☐ Nausea or vomiting

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urinating
- ☐ Lack of bladder control
- ☐ Painful Urination

MUSCLE/JOINT/BONE

Pain, weakness, numbness In:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Sores
- ☐ Sore that won't heal

NEUROLOGICAL
- ☐ Dizziness or
- ☐ Lightheadedness
- ☐ Weakness
- ☐ Fainting
- ☐ Seizures

PSYCHIATRIC
- ☐ Depression
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Stress
- ☐ Trouble concentrating

ENDOCRINE
- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid disease

HEMATOLOGICAL
- ☐ Anemia
- ☐ Bleeding disorder

ALLERGIES
- ☐ Asthma
- ☐ Hayfever or allergic rhinitis

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Abnormal Breast Imaging

Date of last menstrual period

____

Date of last pap smear

____

When was your last mammogram?_____________

Are you pregnant?__________

Number of children?________

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge

Date of last prostate exam

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Physician Signature Date Reviewed