<u>Reason for visit:</u> Lumps:___ Abnormal Mammo:___ Pain:____Discharge:____Other:____
<u>Sex:</u> F____ M___ **<u>Race:</u> White____ Black_____ Yellow_____ Other_____**
<u>Religion:</u> ____________Ht: ___ft. ____ in. Wt: _____lbs.
Breast Pain? Yes____ No____ Nipple Discharge? Yes_____ Color:_____ No_____
Who discovered this breast problem?_____________________When?______________
Do you routinely practice breast self examination? Yes______ No_______

<u>MENSTRUAL and PREGNANCY HISTORY</u>
Age at which menstruation started? _______ Date of most recent period?_______ Age at menopause?____
How many children were born alive?______ Age at your first birth? ______
<u>HORMONE USE</u>
Have you taken birth control pills or any hormones? Yes____ No____
If yes, which one?__________________________ For how long?___________ When?_____________
<u>FAMILY HISTORY OF BREAST OVARIAN CANCER</u>
Has anyone in your family had breast cancer? Yes_____ No_____ ovarian cancer? Yes____ No_____
Who? (give age)____

<u>MAMMOGRAPHY</u>
Have you had a <u>Mammogram?</u> Yes___ No___ When was your most recent?_______ Was this your first?____

<u>DIETARY HISTORY</u>
How many daily cups do you drink of: Coffee_____ Tea____ Cola Soda______
How much chocolate do you have every day? ________________________
Do you attempt to limit your fat intake? Yes_____ No _____
How many times per week do you eat red meat? ____________________
Do you restrict your use of salt or spices? Yes ____ No ____
How many <u>alcoholic drinks</u> do you consume per week? __________

<u>PAST MEDICAL HISTORY</u>
List <u>OPERATION:</u> ____
List <u>MEDICAL ILLNESS:</u> ____
Do you have **<u>MITRAL VALVE PROLAPSE</u>**? YES_________NO_________
Have **YOU** ever had <u>CANCER</u>? Yes _____ No _____ if yes, list type ________________________________
Have you had <u>HEPATITIS</u> ? Yes _____ No _____ Are you <u>HIV/AIDS</u> positive? Yes____ No____
List <u>MEDICATION, VITAMINS and MINERALS</u> taken daily____
____
List <u>DRUG ALLERGIES</u>: ____
Are you sensitive to <u>CODEINE</u>? Yes___ No ___ Are you sensitive to ADHESIVE TAPE? Yes___ No_____

<u>FAMILY HISTORY</u>
Has any "**blood relative**" had <u>CANCER, HEART DISEASE or DIABETES</u>? If yes, list who and what:
____

<u>REVIEW OF SYSTEMS (answer YES or NO)</u>
Do you have difficulty: Seeing? ____ Hearing? ____ Breathing? ____
Do you have: Heart Disease? ____ Digestive problem? _____ Urinary problem? _____
Do you have: Skin problem? ____ Paralysis? _____ Seizures? _____ Do you smoke tobacco? ____
Have you seen a psychiatrist or psychologist in the past 5 years? _____
If yes to any of the above, explain:____

PATIENT NAME (PRINT):____________________________ PATIENT SIGNATURE:____________________
REVIEWED BY:____________________________MD DATE: _____________________