breastlink

New Patient Questionnaire

Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Gender: _____

Reason for consultation: _____

Referring Physician: _____

Medications: *Please list all medications with strengths and doses; and frequency, include prescription and over the counter medications, including aspirin, Motrin, Advil.*

_____
_____
_____
_____
_____

Herbal/Natural Medications: Please list and be inclusive

_____
_____
_____
_____
_____

Past Medical History: Please list all medical problems for which you see or are seeing a physician for

_____
_____
_____
_____
_____

Allergies: Please list all medications you have had an allergic reaction to; include what type of reaction you had.
☐ No Drug Allergies

_____
_____
_____
_____

Do you have a history of sleep apnea? ☐ Yes ☐ No

Prior Surgeries: Please include the surgery and date (year) of surgery.

_____
_____
_____
_____

Health Maintenance: (please mark N/A if not applicable)

Last Mammogram: _____
Last Breast Exam: _____
Last Pap: _____
Last colonoscopy: _____

Social History: Please check applicable items

☐ Married ☐ Divorced ☐ Single ☐ Widowed Occupation: _____

Tobacco:
☐ Never smoked
☐ Currently Smoke _____ packs per day for _____ years
☐ Quit _____ years ago, prior smoked _____ packs per day for _____ years

Alcohol:
☐ Never
☐ Social 1-3 drinks per week
☐ Daily, mild consumption 1 drink per day
☐ Daily, moderate consumption 2-3 drinks per day
☐ Daily, large consumption more than 3 drinks per day
☐ History of alcoholism

Current Symptoms: Have you recently had any of the following: (please check if yes)

General: □Weight loss (how much) _____ □Weight Gain (how much)_____

Skin: □ Skin Problems □ Skin Cancers □Psoriasis □ Other _____

HEENT: □ Visual Problems □ Hearing Problems □ Nose/Throat Infections □ Other _____

Pulmonary: □ Shortness of breath □ chronic cough □ Other _____

Cardiovascular: □ Irregular Heartbeat/Arrhythmia □ History of Heart Attack □ Past Cardiac Surgery □ Other

Peripheral Vascular: □ History of leg cramping with walking □ Other _____

Gastrointestinal: □ Acid Reflux □ Abdominal Pain □ change in bowel habits □ blood in stool □ Other

Genitourinary: □ History of blood in urine □ Incontinence □ Other _____

Endocrine: □ History of thyroid problems □ Diabetes □ Other _____

Hematology/Immune: □ Anemia □ Bleeding Problems □ Auto Immune Disorders □ Other _____

Musculoskeletal: □ Chronic Back Pain □ Neck Pain □Other _____

Neurological/Psych: □ Depression □ Anxiety □ Neurological Disorder _____ □ Other _____

Gynecologic History:

Periods started at age _____ Periods stopped at age _____

How many times have you been pregnant? _____ Age at first live birth _____ How many live births _____

Have you used birth control pills? ☐ Yes ☐ No If so, for how many years? _____

Have you used any hormone replacement? ☐ Yes ☐ No If so, for how many years? _____

Have you been involved in any fertility treatment? ☐ Yes ☐ No If so, how many cycles? _____ clomid / injectables

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, were the cells ever found to be atypical, premalignant or abnormal? ☐ Yes ☐ No

Family History:

Breast Cancer ☐ Yes ☐ No _____

Ovarian Cancer ☐ Yes ☐ No _____

Other Cancer- who and what kind? _____

Other Illness: _____

Have you ever had BRCA testing/Other Genetic testing ☐ Yes ☐ No Results: ☐ Positive ☐ Negative

Ethnicity/Ethnicities: _____

Number of Female relatives: #Daughters_____ #Sisters _____ #Maternal Aunts_____ #Paternal Aunts_____

Is there anything else that we need to know concerning your health?

_____
_____
_____
_____
_____