111.7 New Patient Questionnaire

New Patient Medical Questionnaire

Patient Name: _____ Date of Birth: _____ Date :_____

Primary Care Physician _____Referring Physician: _____

Reason for Visit: □ Abnormal Mammo □ Lump □ Pain □ Nipple discharge □New Cancer Diagnosis
□ 2nd opinion □ Change of Surgeon/Oncologist □ Other _____

Most Recent Mammogram: Date: _____ Place: _____

FAMILY HISTORY (who and age at diagnosis?)

Breast Cancer □ Yes □No _____

Ovarian Cancer □ Yes □No _____

Other Cancer- who and what kind? _____

Other Illness: _____

Have you ever had BRCA testing? □ Yes □ No Results: □ Positive □Negative
Have you ever had other genetic testing? □ Yes □ No Results: □ Positive □Negative

Previous Breast Surgery

History of Breast Cancer □ Yes □No If yes, explain: _____

Other Breast Problems □ Yes □No If yes, explain: _____

Previous Plastic Surgery □ Breast Augmentation □Breast Reduction □ Mastopexy □ Other _____

Implants: Date of placement: _____ Type: _____

Past Surgical History and Dates:

Past Medical History: Please check all problems that you may have/had:

□Anemia	□Emphysema	□High Blood Pressure
□Arthritis	□Excessive Bleeding	□High Cholesterol
□Asthma	□Gastrointestinal disorders	□Kidney Problems
□Autoimmune disorder	□Heart Attack	□Thyroid
□Clotting/ Bleeding disorder	□Heart Problems	□TB
□Depression	□Heart Surgery	□Cancer-what kind?
□Diabetes	□Hepatitis/Jaundice	_____

ALLERGIES: Medications: □ Yes □No Food Allergies: □ Yes □No Latex Allergies: □ Yes □No

If yes, please list: _____

MEDICATION LIST:

_____ _____ _____

_____ _____ _____

_____ _____ _____