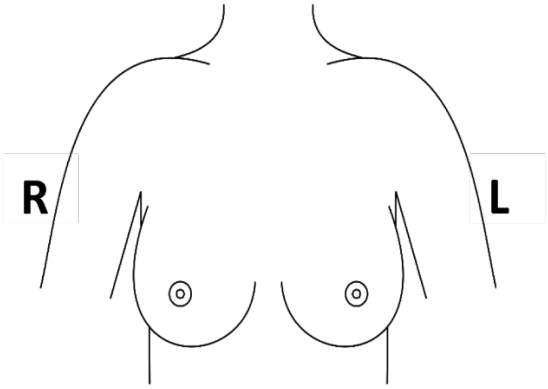
BREAST PATIENT HISTORY FORM

GENERAL SURGERY

Name: _____ DOB: _____ Today's Date: _____

DRAW PROBLEM AREA(S) ON THE FIGURE BELOW: (INCLUDE ANY / ALL OF THESE)



-Breast Lump(s)
-Area of Breast Pain
-Nipple Discharge / changes
-Implants
-Rashes or other skin changes
-Scars
-Other (Describe Symptoms) _____
_____
_____

BREAST SURGERIES, PROCEDURES OR BIOPSIES:

Date: _____ Type: _____ Provider: _____
Date: _____ Type: _____ Provider: _____
Date: _____ Type: _____ Provider: _____

PREVIOUS BREAST CANCER TREATMENT:

Chemotherapy Treatment	Y / N	Date(s): _____	Provider: _____
Radiation Treatment	Y / N	Date(s): _____	Provider: _____
Hormone Treatment	Y / N	Date(s): _____	Provider: _____

FAMILY / PERSONAL HISTORY OF CANCER:

PERSON	BREAST CANCER	AGE	OVARIAN CANCER	AGE	OTHER CANCER	AGE
SELF						
MOTHER						
FATHER						
SISTER						
BROTHER						
CHILD						
OTHER						

GYNECOLOGY HISTORY:

Number of children: _____ Breastfed: Y / N Mastitis/Abscess: Y / N
Have you had your uterus and/or ovaries removed: Y / N If yes, when: _____

PUYALLUP SURGICAL CONSULTANTS
a division of Proliance Surgeons

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PROLIANCE SURGEONS®

REVIEW OF SYSTEMS: Circle those items below that are true for you *at this time.*

Constitutional: *fever; chills; headache; weight gain/loss of more than 10 lbs in last 6 months (circle one)*

Heart: *chest pains; irregular heartbeat; abnormal EKG; heart attack; congestive heart failure*

Lungs: *cough; shortness of breath; coughing up blood; asthma; blood clots in lungs; COPD; emphysema*

Digestive: *loss/decrease in appetite; belly pain or belly cramps; vomiting blood; blood in stool; black stools; nausea; heartburn; change of bowel habits; reflux; jaundice*

Urinary: *difficult or painful urination; blood in urine; difficulty starting stream of urine; kidney stones*

Eyes, Ears, Nose & Throat: *glaucoma; hay fever; sinus problems; difficulty swallowing; deafness*

Circulatory: *leg cramps when walking; feet swell; stroke*

Neurological: *dizziness; stroke; seizures; tingling/numbness; migraines*

Immunologic/hematologic/lymphatic: *blood transfusion; bleeding tendency; swollen glands; AIDS; cancer*

Endocrine: *too hot or cold; excessive thirst; tired; goiter or thyroid problem; diabetes*

Skin: *rash; persistent itching; boils; infections; diseases*

Psychological: *drug or alcohol problems; nervousness; mood changes; psychiatric treatment; memory loss*

Do you take any opioids for chronic pain? ___Yes ___ No Which ones? _____
Are you on a pain contract? ___ Yes ___ No If YES, with whom? _____

PHYSICIAN NOTES: _____

_____