COMPREHENSIVEBREASTCAREOFDENVER

1960 Ogden Street #230
Denver, CO 80218
T: 303.318.3580 F: 303.318.2483

PATIENTS MEDICAL HISTORY

LAST NAME **FIRST** **MI** **D.O.B.** **DATE**

REFERRING PHYSICIAN:_____

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began.

	Problem	Date of onset
1		
2		
3		

GENERAL HEALTH AND HABITS

Characterize your current health status: ☐Excellent ☐Very Good ☐Average ☐ Poor

Exercise
Do you exercise regularly? ☐ Yes No ☐
Type of exercise(s) _____
History of Smoking ☐ Yes No ☐
Specify: _____
How many per day? _____
For how many years?_____
What do you/did you smoke? ☐ Cigarettes ☐ Pipe
☐ Cigars Other (specify)_____
When did you quit smoking? _____

Nutrition
Vitamin/Mineral Supplements_____
Your appetite: ☐Excellent ☐ Good ☐ Fair ☐ Poor
Are there foods you avoid (or limit) for health reasons? Yes ☐ No ☐

Alcohol/Beverages
Estimate the amount of alcohol you drink regularly:
_____drinks per day_____drinks per week
Did you formerly drink alcohol but have
permanently stopped? ☐ Yes No ☐
Estimate the amount of caffeinated beverages (Coffee, Tea, Cola):
you drink per day_____Glasses, Cups or Cans.

PAST MEDICAL AND SURGICAL HISTORY

List the chronologically all your surgeries, including the nature of each operation and where and when performed. (Be accurate and complete. Consult family, friends, physicians, etc).

	Operation	Hospital and City	Date
1			
2			
3			
4			

Have you ever been seriously injured? (If so give details and date)

List	Reason for hospitalization	Hospital and City	Date
1			
2			
3			

COMPREHENSIVEBREASTCAREOFDENVER

1960 Ogden Street #230
Denver, CO 80218
T: 303.318.3580 F: 303.318.2483

CURRENT MEDICATIONS

List all medications you are now taking.

Name of medicine	Strength	How often taken	When began taking

ALLERGIES

Please list allergies to medications and reaction:

PERSONAL HISTORY

Where were you born?
Have you ever lived or traveled extensively abroad?
☐Yes ☐ No
If so, give details:

Have you ever worked in the field of medicine, in any capacity, including volunteer, aide, clerk, or technician?

What is the highest level of education you have attained?

What inhaled chemicals or particles are you exposed to at your place of work?

List the areas you have lived chronologically, giving dates:

	Area	From	To
1			
2			
3			

List your past occupations chronologically, giving dates:

	Occupation	From	To
1			
2			
3			

COMPREHENSIVEBREASTCAREOFDENVER

1960 Ogden Street #230
Denver, CO 80218
T: 303.318.3580 F: 303.318.2483

PERSONAL HISTORY CONTINUED

Have any blood relatives ever had any of the following? (If so, indicate relationship)
Abnormal bleeding or clotting _____
"Heart Attack" _____
Alcoholism _____
Psychiatric disease or suicide _____
A disease which "runs in the family"_____

FAMILY HISTORY OF CANCER

RELATION					
	MOTHER	FATHER	BROTHERS	SISTERS	CHILDREN
AGE OF DIAGNOSIS					
TYPE OF CANCER					
BREAST					
OVARIAN					
PANCREATIC					
STOMACH					
MELANOMA					
OTHER CANCER					

GENERAL FAMILY HEALTH

RELATION	AGE IF ALIVE	AGE OF DEATH	STATE OF HEALTH/CAUSE OF DEATH
MOTHER			
FATHER			
BROTHERS/ SISTERS			
CHILDREN			

COMPREHENSIVE BREAST CARE OF DENVER

1960 Ogden Street #230
Denver, CO 80218
T: 303.318.3580 F: 303.318.2483

REVIEW OF SYSTEMS

BREAST	Yes	No
Have you ever had tumors, cysts,or other breast disease?		
Do you experience nipple discharge?		
Do you experience persistent breast pain?		
Have you ever had a breast biopsy?		
Have you ever had breast surgery?		
When was your last pap smear?		
GYNECOLOGIC OBSTETRIC	Yes	No
If you are still menstruating, **provide date of your last period**		
If you have stopped menstruating, provide **age of your last period**		
Have you had a hysterectomy?		
Age at first pregnancy		
How many times have you been pregnant (including miscarriages)		
How many live births?		
How many years total have you taken hormones or birth control pills?		
RESPIRATORY	Yes	No
Have you ever had any of the following? If so, indicate date.		
Pleurisy		
Tuberculosis skin test		
Tuberculosis (infection or contact)		
Pleurisy		
Tuberculosis skin test		
Tuberculosis (infection or contact)		
Asthma (wheezing)		
Chronic bronchitis		
Emphysema		
Other lung trouble		
Exposure to dangerous dust or fumes		
Excessive snoring		
Chest pain		
Abnormal chest X-ray		
Have you ever coughed up blood?		
Do you often cough?		
Do you often cough up sputum?		

NEUROLOGICAL	Yes	No
Have you ever had:		
Stroke		
Paralysis or muscular weakness		
Neurological disease		
Frequent or recurrent headaches		
Loss of consciousness		
Convulsions and or seizures		
Head injury		
Difficulty with coordination		
Tremor or abnormal movements		
Difficulty walking		
Difficulty speaking		
Double vision or loss of vision		
Numbness		
Difficulty with memory		
Dizziness		
MOOD	Yes	No
Have you recently experienced:		
Severe anxiety, panic, or phobias		
Excessive fatigued		
Depression		
Have you ever:		
Had a nervous breakdown or required psychiatric care		
Had a drug or alcohol problem		
Been involved in domestic violence		
ENDOCRINOLOGY	Yes	No
Have you ever had any of the following? If so, indicate date		
Hormone problems		
Thyroid disease		
Diabetes		

COMPREHENSIVE BREAST CARE OF DENVER

1960 Ogden Street #230
Denver, CO 80218
T: 303.318.3580 F: 303.318.2483

REVIEW OF SYSTEMS CONTINUED

HEMATOLOGY AND ONCOLOGY	Yes	No
Have you ever had:		
Anemia		
Bleeding or bruising tendency		
Cancer or tumor		
X-ray or radiation treatment		
Do you practice breast or testicular self exam?		
CIRCULATORY	Yes	No
Have you ever had any of the following? If so, indicate date		
Chest pain		
Heart trouble		
Heart attack (coronary)		
Angina pectoris		
High cholesterol		
High blood pressure		
Blackouts		
Racing of heart		
Rheumatic fever		
Abnormal cardiogram		
Swelling of your ankles		
Have you ever taken heart or water pills?		
URINARY	Yes	No
Have you ever had		
Kidney disease or nephritis		
Protein or albumin in urine		
Do you have discomfort passing urine? Blood or pus in urine		
Kidney stones		
Urinary infection		
DIGESTIVE	YES	NO
Vomiting blood		
Parasitic infection		
Black or tarry stools		
Yellow jaundice		
Liver problems or hepatitis		
Gallbladder problems or stones		
Persistent diarrhea or colitis		
Diverticulitis		

EYES AND EARS	Yes	No
Have you ever had:		
Glaucoma		
Other major eye diseases		
Deafness		
Abnormal noises in the ear		
ALLERGY AND IMMUNOLOGY	Yes	No
Have you ever had:		
Asthma		
A reaction to penicillin		
A reaction to aspirin		
A reaction to any other drug (Specify)		
Date and type of immunization :		
Tetanus-Diphtheria (every 10 years)		
JOINTS	Yes	No
Have you ever had any of the following? If so, indicate date.		
Muscle Pain		
Back pain		
Joint pain/swelling		
Osteoarthritis		
Gout		
Have you been diagnosed with rheumatoid arthritis?		
CUTANEOUS	Yes	No
Have you ever had:		
Skin rashes		
Skin cancer		
DIGESTIVE	Yes	No
Do you regularly have:		
Poor appetite		
Trouble swallowing		
Heartburn		
Regurgitation of food or bile		
Nausea or vomiting		
Constipation		
Diarrhea		
Has there been any change in your bowel function in the past 6 months?		
Hiatal or esophageal hernia		
Duodenal or gastric ulcer		