

COMPREHENSIVE BREAST CARE OF DENVER

1825 Marion Street
Denver, CO 80218
T:303.318.3413 F:303.318.3439

CURRENT MEDICATIONS

List all the medications you are now taking.

Name of medicine	Strength	How often taken	When began taking

PERSONAL HISTORY

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

List the areas you have lived in chronologically, giving dates:

	Area	From	To
1			
2			
3			

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

List your past occupations chronologically, giving dates:

	Occupation	From	To
1			
2			
3			

What is the highest level of education you have attained?

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

FAMILY HEALTH

Please give the following information about the health of your immediate family:

Relation	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			

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Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Cancer (specify type if known) _____

Abnormal bleeding or clotting _____

“Heart Attack” _____

Alcoholism _____

Psychiatric disease or suicide _____

A disease which “runs in the family” _____

REVIEW OF SYSTEMS

	No	Yes		No	Yes
Do you have discomfort passing urine?			Stroke?		
OBSTETRIC AND GYNECOLOGICAL			Paralysis or muscular weakness?		
Have you ever had tumor(s), cyst(s), or other breast disease?			Tremor or abnormal movements?		
How many times have you been pregnant (including miscarriages)?			Difficulty with coordination?		
How many live births?			Difficulty in walking?		
At what age did you begin to menstruate?			Difficulty in speaking?		
Have you had a hysterectomy?			Double vision or loss of vision?		
Are you now taking hormones or birth control pills?			Numbness?		
When was your last Pap smear?			Difficulty with memory?		
If you are still menstruating:			Dizziness?		
When was your last period?			MOOD		
The one before that?			Have you recently:		
If you had menopause:			Experienced sever anxiety, panic, or phobias?		
When was your last period?			Felt excessively fatigued?		
Have you bled since?			Felt depressed?		
Last Mammogram?			Have you ever:		
HEMATOLOGY AND ONCOLOGY			Had a nervous breakdown or psychiatric care?		
Have you ever had:			Had a drug or alcohol problem?		
Anemia?			Been involved with domestic		

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			violence?		
	No	Yes		No	Yes
Bleeding or bruising tendency?			EYES AND EARS		
Cancer or tumor?			Have you ever had:		
X-ray or radiation treatment?			Glaucoma?		
Do you practice breast or testicular self exam?			Other major eye diseases?		
NEUROLOGICAL			Deafness?		
Have you ever had:			Abnormal noises in the ear?		
Neurological disease?			ALLERGY AND IMMUNOLOGY		
Frequent or recurrent headaches?			Have you ever had:		
Loss of consciousness?			Asthma?		
Convulsions or or seizures?			A reaction to penicillin?		
Head injury?			A reaction to aspirin?		
RESPIRATORY			A reaction to any other drug? (Specify)		
Have you ever had any of the following? If so, indicate when.			Date of last immunization for:		
Pleurisy			Tetanus-Diphtheria (every 10 yrs.)		
Tuberculosis skin test			Pneumococcal Pneumonia (Pneumovax)		
Tuberculosis (infection or contact)			Influenza (annual -Fall)		
Asthma (wheezing)			JOINTS		
Chronic bronchitis			Have you ever had any of the following? If so, indicate when.		
Emphysema			Muscle pain		
Other lung trouble			Back pain		
Exposure to dangerous dust or fumes			Joint pain		
Trouble breathing			Joint swelling		
Excessive snoring			Gout		
Do you have chest pain?			Has your doctor diagnosed arthritis, rheumatism?		
Abnormal chest x-ray?			CUTANEOUS		
Have you ever coughed up blood?			Have you ever had:		
Do you often cough?			Skin rashes?		

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Do you often raise sputum?			Skin cancer?		
	No	Yes		No	Yes
Do you often get chest colds?			DIGESTIVE		
When was your last chest x-ray?			Do you often or regularly have:		
CIRCULATORY			Poor appetite?		
Have you ever had any of the following? If so, indicate when.			Trouble swallowing?		
Chest pain			Heartburn?		
Heart trouble			Regurgitation of food or bile?		
Heart attack?(coronary)			Nausea or vomiting?		
Angina pectoris			Abdominal pain?		
High cholesterol			Constipation?		
High blood pressure			Diarrhea?		
Blackouts			Has there been any change in your bowel functioning in the past 6 mos.?		
Racing of heart			Have you ever had any of the following? If so, indicate when.		
Rheumatic fever			Hiatal or esophageal hernia		
Heart failure			Duodenal or gastric ulcer		
Abnormal cardiogram			Vomiting of blood		
Swelling of your ankles			Black or tarry stools		
Have you ever taken heart or water pills?			Stool Cards		
When was your last EKG?			Yellow jaundice		
ENDOCRINOLOGY			Liver trouble or hepatitis		
Have you ever had any of the following? If so, indicate when.			Gallbladder trouble or stones		
Hormone problems			Persistent diarrhea or colitis		
Thyroid disease			Diverticulitis		
Diabetes			Parasitic infection		
Osteoporosis			Hernia		
URINARY			Other digestive disease		
Have you ever had:			When was your last colonoscopy?		
Kidney disease or nephritis					
Protein or albumin in urine					
Blood or pus in urine					

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	No	Yes			
Kidney stones					
Urinary infection					
Prostate infection					