

St. Luke's Comprehensive Breast Care Program – Medical History

Date of Visit _____

Full Name: _____ Date of Birth: _____ Age: _____

History of Current Problem

Reason for you visit: _____

- What was the first indication of your current breast problem? (Choose one)
 - Abnormal mammogram
 - Lump in breast
 - A lump you discovered
 - A lump your physician discovered
 - Mass in armpit (axilla)
 - Inverted nipple
 - Bloody discharge
 - Breast pain or discomfort
 - Skin changes/discoloration
 - Other

- Approximately what date was this problem first noted? (m/d/y) _____

- Check if you have ever had any of the following:
 - Breast tenderness
 - Related to menstrual cycle
 - NOT related to menstrual cycle
 - Generalized lumpiness or fibrocystic changes
 - Cysts (fluid-filled lumps)
 - Solid lumps
 - Mastitis (infection of breast)
 - After childbirth/breast feeding
 - At any other time
 - Nipple discharge
 - Spontaneous
 - Bloody
 - Mammographic change

- Have you ever had a breast biopsy? Yes No

Number of biopsies	
Left	Right

- Have any of these been malignant?

Date of biopsy	Right or Left	Pathology

- When was your last mammogram? (m/d/y) _____
- Place/location of your last mammogram? _____
- Have you ever had an abnormal mammogram? Yes No
- How often do you perform self-breast exams?
 - Monthly
 - Every couple of months
 - Rarely
 - Never
- Would you like instruction or review on performing a self-breast exam? Yes No

Past Medical History

OB/Gyn History:

- How old were you when you had your first period? Age _____
- Have you ever been pregnant?
 - No
 - Yes, number of pregnancies _____. Number of live births _____
If yes, how old were YOU when your FIRST child was born? Age: _____
- Are you pregnant now? Yes No Unsure
- Have you ever used any of the following birth control methods? (how long?):
 - Shots (DeproProvera) _____ Barrier (foam, condom, suppositories, IUD)
 - Implant (Norplant) _____
 - Birth control pills _____ Sterilization (tubal, vasectomy)
- Have you ever used, or do you currently use hormone replacement?
 - No, never yes, currently yes, in the past
- If you used hormone replacement, currently or in the past, what type(s) do/did you use?
 - Combination Estrogen/Progesterone (Premarin, Estrace, Prempro, Climara, Estratest, etc.)
 - Progesterone only (Provera, Prempro, etc.) Years taken: _____
- If you have had a hysterectomy, which of the following applies to you:
 - Both ovaries were removed, Date of surgery (m/d/y) _____
 - Both ovaries were NOT removed
 - Only one ovary was removed. (circle one): Left Right
 - Not sure if both ovaries were removed

Allergies

- Please list ALL food and drug allergies
 - Check here if you have no known allergies.

Name	Type of reaction

Medications

- Please list all medications, pills, home remedies, herbal supplements, and sleep aids that you take or use at home.

Check here if you take no medications, pills, home remedies or herbal supplements.

Medication	Reason	Dose	How Often

Surgery

- Please list all previous surgeries:

Check here if you never had surgery.

Surgery	Date	Any problems with surgery or anesthesia?

Social History

- What best describes your racial background? (Choose one)
 - Caucasian/White
 - African American
 - Asian or Pacific Islander
 - American Indian, Aleutian, or Eskimo
 - Spanish/Hispanic
 - Ashkenazi Jewish
 - Other

- Have you ever smoked cigarettes?
 - No, never
 - Yes; but only in the past: date stopped (m/d/y) _____
 - Yes; currently
 - How long have you been smoking? _____ years
 - If you have ever smoked, on average, how many packs per day did you smoke, or do you currently smoke? _____

- Do you drink alcoholic beverage (beer, wine, liquor, mixed drinks, etc.)?
 - No
 - Yes, How many alcoholic beverages do you consume weekly? _____

- What is/was your occupation? _____

Family History

- Do any of these diseases run in your family? (If “yes,” please describe below)
 - Nervous/Psychiatric diseases
 - Blood/Clotting System
 - Diabetes
 - Other
 - Heart diseases
 - Lung diseases
 - Liver diseases
 - Stomach/Intestinal diseases
 - Kidney diseases

- Have you ever been diagnosed with cancer?
 - No
 - Yes Type of cancer: _____
 - How old were you at the time of your diagnosis? _____

- Have any of your relatives been diagnosed with cancer?
 - Please check here if you family cancer history is unknown.

	Yes	No	Type of cancer (comments?)		Age at diagnosis
Father	<input type="checkbox"/>	<input type="checkbox"/>			
Mother	<input type="checkbox"/>	<input type="checkbox"/>			
Brother	<input type="checkbox"/>	<input type="checkbox"/>			
Brother	<input type="checkbox"/>	<input type="checkbox"/>			
Brother	<input type="checkbox"/>	<input type="checkbox"/>			
Sister	<input type="checkbox"/>	<input type="checkbox"/>			
Sister	<input type="checkbox"/>	<input type="checkbox"/>			
Sister	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
Child	<input type="checkbox"/>	<input type="checkbox"/>			
			Mother's Side	Father's Side	
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>			
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>			
Aunt	<input type="checkbox"/>	<input type="checkbox"/>			
Aunt	<input type="checkbox"/>	<input type="checkbox"/>			
Uncle	<input type="checkbox"/>	<input type="checkbox"/>			
Uncle	<input type="checkbox"/>	<input type="checkbox"/>			

Review of Systems

Please check any of the problems that you have:

- Check here if you have no symptoms/problems

<p>General:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weakness <input type="checkbox"/> Weight gain _____ lbs. <input type="checkbox"/> Weight loss _____ lbs. <input type="checkbox"/> Night sweats <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Fever <input type="checkbox"/> Bone pain <input type="checkbox"/> Pain _____ 	<p>Skin/Teeth/Thyroid:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lumps <input type="checkbox"/> Jaundice <input type="checkbox"/> Bruises <input type="checkbox"/> Wounds/sores <input type="checkbox"/> Thyroid disorder 	<p>Lungs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough/sputum/phlegm <input type="checkbox"/> Painful breathing <input type="checkbox"/> Difficulty sleeping flat <input type="checkbox"/> Difficulty climbing a flight of stairs <input type="checkbox"/> Difficulty walking one block <input type="checkbox"/> History of asthma <input type="checkbox"/> History of oxygen use
<p>Heart/Circulation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Blood pressure problems/hypertension <input type="checkbox"/> Chest/jaw/arm pain <input type="checkbox"/> Fast or slow heart beats <input type="checkbox"/> Palpitations <input type="checkbox"/> Blood clot history <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Heart attack history <input type="checkbox"/> Cardiac catheterization 	<p>Foods/Fluids:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Frequent indigestion <input type="checkbox"/> Appetite change <input type="checkbox"/> Sore throat/mouth <input type="checkbox"/> Special diet <input type="checkbox"/> _____ <input type="checkbox"/> Caffeine (amt/day) <input type="checkbox"/> _____ 	<p>Stomach/Bowel:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation diarrhea <input type="checkbox"/> Bleeding from rectum <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Use of laxatives <input type="checkbox"/> Frequent use of antacids <input type="checkbox"/> Ulcer history <input type="checkbox"/> History of liver problems
<p>Bladder:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain or burning <input type="checkbox"/> Incomplete emptying <input type="checkbox"/> Infection kidney stones 	<p>Neurosensory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Hearing problem <input type="checkbox"/> Hearing aid <input type="checkbox"/> Glasses/contacts 	

Please list any other medical problems that are not listed above.

Please stop here!

Mammograms/Ultrasound:

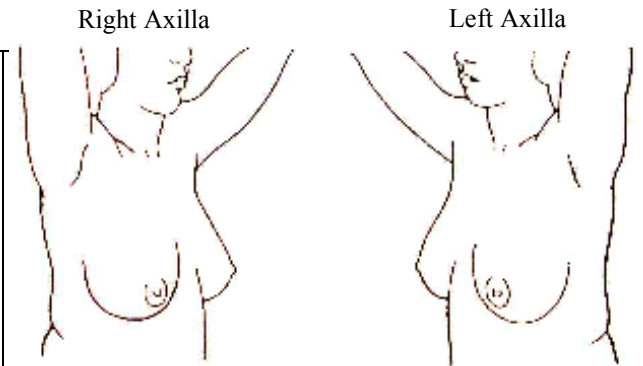
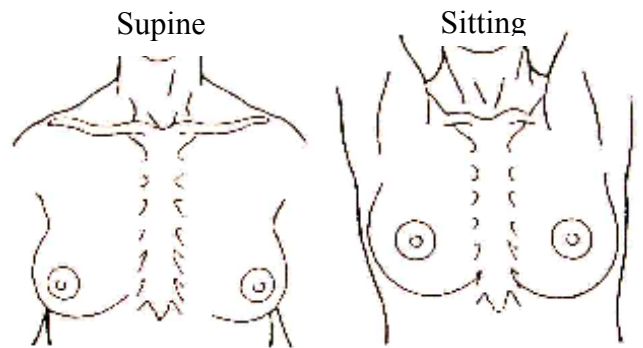
MG/US	Date	Location	Left	Right	Comment

New Mass (NM) Microcalcifications (MC)

Pathology

Date	Location & No.	Type	Pathology

Nurses Notes			
Height: _____	Weight: _____		
BP _____	P _____	R _____	T _____



General:
 Well developed, well nourished _____ who appears their stated age with no obvious deformities

HEENT:
 PERRL, EOMI, sclera anicteric. There is no oral/nasal pathology and the thyroid is normal to inspection and palpation. There is no appreciable cervical adenopathy, no carotid bruits and the CN II-XII are grossly intact.

Chest/Cardiovascular:
 The chest is normal to inspection, clear to auscultation and there are bilaterally symmetrical breath sounds. There is a RRR, NI S1/S2, No murmurs, rubs or gallops. Pulses +2/4 @ radial/DP and symmetrical

Abdomen:
 The abdomen is normal to inspection/percussion. It is soft, nontender. There are normal bowel sounds. There is no evidence of hepatosplenomegaly. There are no abnormal masses.

Extremities:
 There is no clubbing, cyanosis or edema, there are no abnormal skin lesions and sensation is intact to light touch

Skin changes Yes No Left/Right
 Asymmetry Yes No Left/Right
 Nipple discharge Yes No Left/Right
 Dominant mass Yes No Left/Right

Impression

Clinical	T	N	M	S
Pathologic	T	N	M	S

Plan

Examining Physician Signature
