Hunterdon Health

Patient's Name:_____

Date of Birth:_____ Age:_____

REASON FOR YOUR VISIT_____

_____

_____

BREAST HISTORY

Have you had any of the following: Date

- ❑ Breast Needle Biopsy (Stereotactic/Ultrasound Guided) _____
- ❑ Excisional Breast Biopsy _____
- ❑ Other Breast Surgery Type:_____ _____

# of Pregnancies:_____ # of Children:_____ Age at First Birth:_____ Did You Breastfeed? Y❑ N❑

Last Menstrual Period:_____ Age of First Period:_____ Age of Menopause: _____

Have you ever been on Hormonal Replacement Therapy? N ❑ Y ❑ How Long?_____

Have you ever been on Birth Control? N ❑ Y ❑ How Long?_____

Are you of Ashkenazi Jewish Descent? N ❑ Y ❑

FAMILY HISTORY

Do you have a family history of cancer? (i.e. parents, siblings, grandparents, aunts, uncles, cousins, children)

RELATION	CANCER TYPE	AGE OF DIAGNOSIS

Have you had Genetic Testing done? N ❑ Y ❑ When?_____ Results?_____

Have any family members had Genetic Testing done? N ❑ Y ❑ Who?_____ Results?_____

Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY

❑ Diabetes ❑ Stents ❑ High Cholesterol ❑ Blood Clots

❑ Heart Disease ❑ Stroke ❑ High Blood Pressure ❑ Taking Blood Thinners (kind:_____)

❑ Bleeding Tendencies ❑ Depression ❑ Anxiety ❑ Cancer (type:_____)

Other:_____

_____

_____

PAST SURGICAL HISTORY

Have you ever had surgery? ❑ Yes ❑ No

Type:_____

_____

_____

SOCIAL HISTORY

Tobacco Use: ❑ Never ❑ Current ❑ Prior Packs per day_____ Years Smoked_____ Years Quit_____

Alcohol Use: ❑ Never ❑ Occasional ❑ Regularly # of drinks per week:_____

Drug Use: ❑ Yes ❑ No

ANY PROBLEMS IN THE FOLLOWING AREAS

❑ Fever
❑ Chills
❑ Fatigue
❑ Night Sweats
❑ Weight Change
❑ Visual/Hearing Changes
❑ Cough
❑ Shortness of Breath
❑ Chest Pain
❑ Palpitations
❑ Edema
❑ Abdominal Pain
❑ Nausea
❑ Vomiting
❑ Bloody Stools
❑ Constipation
❑ Diarrhea

❑ Blood in Urine
❑ Urinary Frequency
❑ Urinary Incontinence
❑ Hot Flashes
❑ Irregular Menses
❑ Abnormal Vaginal Bleeding
❑ Hair Loss
❑ Rash
❑ Skin Lesions
❑ Dizziness
❑ Headache
❑ Seizures
❑ Tremors
❑ Anxiety
❑ Depression
❑ Insomnia

❑ Joint Pain
❑ Joint Swelling
❑ Muscle Weakness
❑ Easy Bleeding
❑ Easy Bruising
❑ Enlarged Lymph Nodes

Name:_____ Date of Birth:_____

Allergies

ALLERGY	REACTION
MEDICATION:	
FOOD:	
TAPE:	
IV CONTRAST DYE:	
LATEX:	
OTHER:	

Medication List

Please write all medications taken on a regular basis. Include non-prescription, vitamins and/or dietary supplements.

If you prefer to bring a printed/typed list of current medications, please present to reception for copy upon registration.

MEDICATION	DOSAGE/TIMES PER DAY