



Hunterdon Health

Hunterdon Breast Surgery Center

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)

<u>RELATION</u>	<u>CANCER TYPE</u>	<u>AGE OF DIAGNOSIS</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

- | | | | |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stents | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Taking Blood Thinners (kind: _____) |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> 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

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Irregular Menses | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Visual/Hearing Changes | <input type="checkbox"/> Abnormal Vaginal Bleeding | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hair Loss | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Skin Lesions | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Diarrhea | | |

