Name: _____
Age: _____
PCP: _____
Other MD/NP: _____
Date: _____

VS: HT _____ WT: _____ BMI: _____ T: _____ P: _____ R: _____ BP: _____

REASON FOR TODAY'S VISIT:

Please tell us when you last had the following and indicate results normal or abnormal:
Breast Imaging:

Type:

Colonoscopy (50-75):

Prostate Exam:

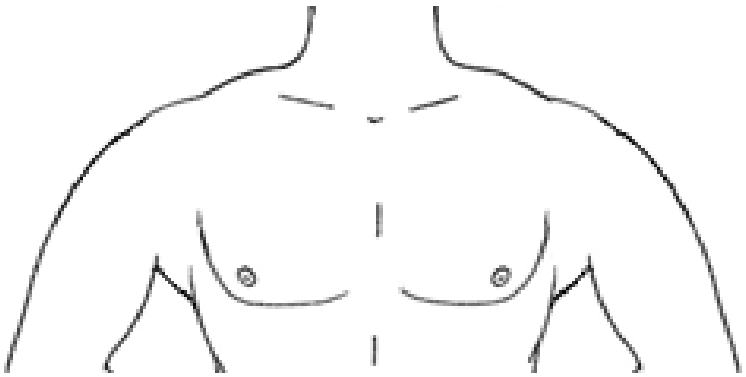
Skin Check:

Flu Shot:

Pneumonia Vaccine (>65):

Falls in Past 6mo (>65)

NOTES:



Name: _____
Age: _____
Referring MD/NP: _____
Other MD/NP: _____
Date: _____

REASON FOR TODAY'S VISIT: ***(Please check all that apply)***

	CURRENT	PRIOR		CURRENT	PRIOR
Breast lump (you/doctor can feel)	[ ]	[ ]	Nipple Symptoms	[ ]	[ ]
Enlargement of breast tissue	[ ]	[ ]	Breast Pain	[ ]	[ ]
Family history of breast cancer	[ ]	[ ]	Other	[ ]	[ ]

PAST MEDICAL HISTORY: Please list all medical conditions that you have or have had in the past.

[ ] I have no significant medical problems

PAST SURGICAL HISTORY: Please approximate date and type of surgery:

[ ] I have never had surgery

PRIOR BREAST BIOPSIES

Have you had any breast biopsies? [ ] YES [ ] NO

If yes, what type? [ ] Surgical [ ] Core Needle [ ] Fine Needle Aspiration

Year and side(s):_____

Reason for the biopsy: _____

Result: _____

BREAST IMAGING:

Mammogram: Date ____/____/____ Place: _____

Ultrasound: Date ____/____/____ Place: _____

MRI: **Date ____/____/____** **Place: _____**

SOCIAL HISTORY: **Please use the back of the page if you need more space**

	NEVER	PRIOR	CURRENT	AMOUNT	HOW LONG?
Cigarettes/Cigars					
Alcohol					
Other (type?)					
Marijuana					

Hormone Replacement Therapy? **[ ] YES** **[ ] NO**

What type(s): _____

Are you currently taking HRT? **[ ] YES** **[ ] NO**

Total years of use _____ How long ago did you stop? _____

Occupation: _____ Marital Status: _____

Who do you live with? _____

FAMILY HISTORY: **Please list all relatives who have had any type of cancer:**

Relative	Mother's or Father's Side	Age at Diagnosis	Type of Cancer

[ ] NONE KNOWN

Please list any other diseases that run in the family, such as heart disease or diabetes:

[ ] NONE KNOWN

Please include any other history which you think is important:

Patient Signature: _____ Date: ____/_____/_____

As a courtesy, we will forward a letter to your PCP and 1 other physician.

Please list physician(s) here: _____

(name & address)

_____

(name & address)