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:

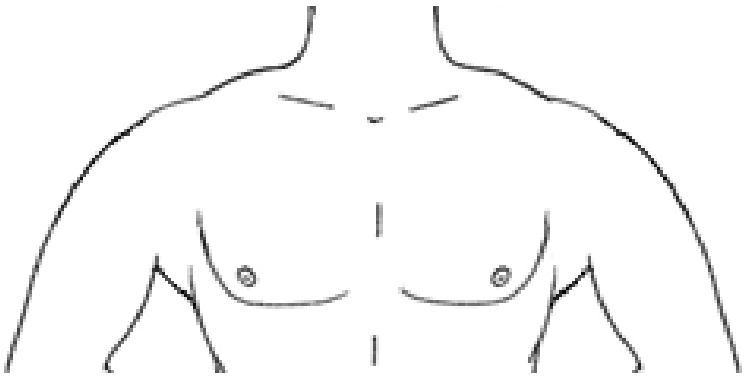
Skin Check:

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)