Arizona Breast Consultants

Today's Date _____

Patient _____ **DOB** _____

*****Please complete ENTIRE form. Mark "N/A" for areas that do not pertain to you*****

Race [ ] African American/Black [ ] Native Hawaiian [ ] Multi-racial
[ ] Asian [ ] Native American/Alaskan [ ] Not Reported
[ ] Caucasian/White [ ] Other Pacific Islander

Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Not Reported

Preferred Language [ ] English [ ] Spanish [ ] Other _____

Internist/Family Doctor _____

OB/Gynecologist _____

Chief Complaint/Concerns _____

First Noticed _____ **Severity or size** _____

Possible Causes (stress, medications, menstrual cycle) _____

Medication Allergies	**Reaction**

Current Prescribed Medications and Dosage

1. _____ **6.** _____
2. _____ **7.** _____
3. _____ **8.** _____
4. _____ **9.** _____
5. _____ **10.** _____

Medical Condition History – Please CHECK ALL that apply

[ ] Anemia
[ ] Anxiety and Depression
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disorder
[ ] BRCA Positive/Negative
[ ] Clotting
[ ] Depression
[ ] Diabetes
[ ] Emphysema
[ ] Excessive Bleeding
[ ] Heart Attack (MI)
[ ] Heart Problems
[ ] Heart Surgery
[ ] Hepatitis or Jaundice
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV or AIDS
[ ] Kidney Problems
[ ] Stroke
[ ] TB (Tuberculosis)
[ ] Thyroid Disease
[ ] Ulcers

[ ] Cancer – Type/Year Diagnosed _____

Family History of Breast Cancer

Please list APPROXIMATE AGE of diagnosis.

First Degree Relatives: Self _____ Mother _____ Sister(s) _____ Daughter(s) _____

Maternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____

Paternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____

BRCA Positive: Mother _____ Sister(s) _____ Daughter(s) _____ Grandmother(s) _____ Aunt(s) _____

Family History *(First Degree Relatives ONLY – Parents, Siblings, Offspring)*

Has anyone in your family had any of the following? List family member & current age or age deceased.

Cancer – List Type _____

Diabetes _____

Heart Attack _____

Heart Failure _____

High Blood Pressure _____

Stroke _____

Social History

Do you currently use tobacco products? _____ Packs daily? _____ How long? _____ Former user? _____

Do you drink caffeine? _____ Servings per day: Coffee _____ Tea _____ Cola _____

Do you drink alcohol? _____ Type _____ How often? _____

Is there any history of illegal drug use? _____ **This information is strictly confidential and is for medical purposes only**

Female History

Age Menstrual Cycle Began _____ Date of Last Menstrual Period _____ Menopause Age _____

Age at delivery of first live child _____ Pregnancies (How many?) _____ Number of Children - Boys _____ Girls _____

Are you taking hormones? ____ Have you in the past? ____ What kind? _____ Date Stopped _____

Past Surgical History

Please indicate side. (Right, Left, or Both)

Procedure/Surgery	Condition	Year

Preferred Pharmacy _____

Pharmacy Cross Streets _____