LOURDES
Breast Care Center

History and Physical

Print Form | Clear Form

Patient Label

Name: _____ Date of Birth: _____ Age: _____ Today's Date _____

List name and address (if not local) of your current healthcare providers:

What is the main reason(s) for your visit today?

Previous Mammogram or Ultrasound

☐ Mammogram Date: Outcome:
☐ Breast Ultrasound Date: Outcome:
Location:

Your Past Medical History (Please mark yes or no for each item)

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma/Emphysema	☐	☐	GERD (reflux)/Ulcer	☐	☐	DES Exposure
☐	☐	Pneumonia	☐	☐	Colitis/Crohn's Disease	☐	☐	Sexually Transmitted Disease
☐	☐	Tuberculosis	☐	☐	Kidney Disease/Stones	☐	☐	Depression/Anxiety
☐	☐	Rheumatic Fever	☐	☐	Liver Disease/Hepatitis/Jaundice	☐	☐	Panic Attack
☐	☐	High Blood Pressure	☐	☐	Seizures/Epilepsy	☐	☐	Suicide Attempt
☐	☐	High Cholesterol/Triglycerides	☐	☐	Neuropathy	☐	☐	Memory Loss/Dementia
☐	☐	Heart Attack	☐	☐	Glaucoma	☐	☐	Bleeding Disorders
☐	☐	Angina/Chest Pain	☐	☐	Migraines/Headaches	☐	☐	Clotting Disorder/DVT/PE
☐	☐	Irregular Heartbeat	☐	☐	Stroke/Mini-stroke	☐	☐	Anemia
☐	☐	Heart Failure	☐	☐	Arthritis	☐	☐	Psoriasis/Eczema
☐	☐	Circulation Problems	☐	☐	Osteopenia/Osteoporosis			
☐	☐	Diabetes	☐	☐	Lupus/Autoimmune disorder			
☐	☐	Thyroid (hypo/hyper)	☐	☐	Fibromyalgia			

List all hospitalizations and surgeries (including laser/cryosurgery), including dates: *(more space on back)*

List all medicines and supplements you take, including dose and how often: *(more space on back)*

List all medication, environmental or food allergies and describe reaction: *(more space on back)*

Latex allergy? ☐ Yes ☐ No
Betadine (iodine) or other antiseptic allergy? ☐ Yes ☐ No
Local anesthesia (lidocaine/novacaine) allergy? ☐ Yes ☐ No
Epinephrine reaction? ☐ Yes ☐ No

Have you ever had any problems with general anesthesia? ☐ Yes ☐ No

Do you use any blood thinning medications like aspirin, Coumadin, Plavix, etc.? ☐ Yes ☐ No

Re-Order # 7250-005 2/25/13 PB001, single side, 2-h

Patient Label

Gynecological History

List Hormones ever used:		How long?	
Date of Last Pap Smear:	Prior abnormal Pap Smears? ☐ Yes ☐ No		
Age of First Menstrual Period:	First Day of Last Menstrual Period:		
Age of First Pregnancy:	Number of Pregnancies:	Number of Children:	Could you be Pregnant now?
If you breastfed, for how long?	How often do you perform Breast Self-Examination?		

Patient Social History

Marital Status:	☐ Single	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Widowed

Occupation: Do you live alone? ☐ Yes ☐ No If no, whom do you live with?

Have you ever used

Caffeine ☐ Yes ☐ No	Tobacco ☐ Yes ☐ No	Alcohol ☐ Yes ☐ No	Recreational drugs ☐ Yes ☐ No

Family History

Has your blood relative been diagnosed with (Check all that apply)

	Diabetes	Heart Disease	High Blood Pressure	Stroke
Family Member	Age at Diagnosis	Age at Diagnosis	Age at Diagnosis	Age at Diagnosis
☐ Mother				
☐ Father				
☐ Brother				
☐ Sister				

Your Review of Systems (Please mark yes or no for each item)

Yes	No	Constitutional	Yes	No	Genitourinary
☐	☐	Fever / chills	☐	☐	Urinary frequency / urgency / dribbling
☐	☐	Frequent colds / infections	☐	☐	Painful urination
☐	☐	Insomnia	☐	☐	Blood in urine
☐	☐	Fatigue	☐	☐	Discharge from vagina
☐	☐	Headaches	☐	☐	Irregular menstrual cycles / spotting
☐	☐	Recent weight loss or gain	☐	☐	Loss of sex drive
		HEENT	☐	☐	Hernia
☐	☐	Blurred vision / double vision			Neurologic
☐	☐	Hearing loss	☐	☐	Tremors
☐	☐	Hoarseness / trouble swallowing	☐	☐	Dizzy spells / fainting / light headedness
		Respiratory	☐	☐	Numbness / tingling
☐	☐	Shortness of breath	☐	☐	Confusion / memory loss
☐	☐	Chronic or frequent cough			Endocrine
☐	☐	Wheezing	☐	☐	Hot flashes / night sweats
		Cardiovascular	☐	☐	Excessive thirst or urination
☐	☐	Chest pain	☐	☐	Heat or cold intolerance
☐	☐	Heart murmur	☐	☐	Hair loss or overgrowth
☐	☐	Irregular heart beat			Hematologic / Lymphatic
☐	☐	Varicose veins	☐	☐	Swollen glands / lymph nodes
☐	☐	Swelling in arms / legs	☐	☐	Bleeding or easy bruising
		Gastrointestinal			Musculoskeletal / Integument
☐	☐	Loss of appetite	☐	☐	Rash / itching
☐	☐	Abdominal pain / bloating	☐	☐	Muscle weakness / imbalance
☐	☐	Nausea / vomiting	☐	☐	Bone pain
☐	☐	Jaundice			Psychological
☐	☐	Heartburn / indigestion	☐	☐	Depression
☐	☐	Diarrhea	☐	☐	Anxiety / Nervousness
☐	☐	Constipation	☐	☐	Mood swings
☐	☐	Hemorrhoids	☐	☐	Suicidal thoughts

Patient Label

Risk Assessment

Age:	Height:	Weight:	Today's Date

Have you ever had a **breast biopsy**? ☐ Yes ☐ No

Did any of your biopsies show: Atypical Hyperplasia ☐ Yes ☐ No (☐ ductal and/or ☐ lobular)

Lobular Carcinoma in Situ (LCIS) ☐ Yes ☐ No

Have you had **repeated radiation exposure** to the chest (chest x-rays, treatment for Hodgkins Lymphoma)? ☐ Yes ☐ No

Have you ever taken? Tamoxifen (Nolvadex) ☐ Yes ☐ No Raloxifene (Evista) ☐ Yes ☐ No

Have you or a family member ever had **genetic testing**? ☐ Yes ☐ No ☐ Unknown

Please select what best describes your **ethnicity**? (We ask these questions because it helps us determine your risk of hereditary cancer.)

☐ African American or Black ☐ Caribbean/West Indian ☐ Indian/Aleutian/Eskimo

☐ Asian or Pacific Islander ☐ Caucasian or White ☐ Spanish/Hispanic

Are any of your ancestors of **Jewish descent**? ☐ Yes ☐ No

*Record below which of your relatives have had **cancer** and age at which they were diagnosed.*

Type of Cancer	Which family members and age at diagnosis
Brain	
Breast	
Cervical	
Colon or Rectal	
Kidney or Bladder	
Leukemia	
Liver	
Lung	
Lymphoma	
Melanoma	
Ovarian	
Pancreatic	
Prostate	
Sarcoma	
Stomach	
Thyroid	
Uterine	

Do you come from a ☐ small family ☐ medium family ☐ large family? (check the box that best represents your family size)

Patient /Authorized Representative Signature: _____ *Date:* _____ *Time:* _____

Reviewing/Attending Provider Signature: _____ *Date:*_____ *Time:*_____