

Patient Name: _____ DATE: _____

Past Medical History

Check if you are currently being treated or have been treated for any of the following illnesses:

- Heart problems
- High blood pressure
- Diabetes
- Cancer
- Asthma
- Other _____

Women Only:

Age at first period: _____

Number of pregnancies: _____

Number of children: _____

Age at first birth: _____

Age at menopause: _____

Number of previous breast biopsies: _____

Family history of breast/ovarian cancer: _____

History of Tamoxifen or Evista use: _____

Are you allergic to any **medications**? Yes No

If yes, please specify medication and describe reaction: _____

Do you have a **pacemaker**? Yes No

Are you presently on **dialysis**? Yes No

Have you had any **operations**? Please list type of surgery and approximate date:

PLEASE LIST MEDICATIONS THAT YOU ARE TAKING. WE CAN COPY A LIST. IF YOU ARE NOT TAKING ANY PLEASE LIST NONE TAKEN.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Social History

Marital Status: S M W D

Health Habits:

Do you smoke? Yes No How many packs per day? _____ How many years? _____

Do you drink alcohol? Yes No How much? _____

Do you use any recreational drugs? Yes No

Family History

Check if any close family members (parents, siblings, children) have/had:

Heart problems High blood pressure Diabetes Cancer

Other _____