CENTER FOR Breast Health & IMAGING STARKVILLE, MS

OCH CENTER FOR BREAST HEALTH

OCH CENTER FOR BREAST HEALTH
PATIENT HISTORY AND PHYSICAL

Reason for visit:

________Routine Follow-up ________Nipple Discharge

________Breast Lump: Left or Right ________Breast Pain or Tenderness

________Abnormal Mammogram
________Other Please Explain____

Please list the name and city of your **PRIMARY PHARMACY**

Name:____ City:____

Are you taking any medications?______Yes______No

Please list any current medications including prescription, over the counter and herbal

Name of Medication	Dosage	How Often

Are you allergic to any medication?________Yes________No

Name of Medication	Type of Reaction

Please list all surgeries you have had and include dates

Procedure/Surgery	Date

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Medical History

Have you ever been diagnosed with the following problems?

Liver Disease	______Yes_______No	Emphysema	______Yes_______No
Asthma	______Yes_______No	HIV	______Yes_______No
Kidney Disease	______Yes_______No	Seizures	______Yes_______No
Anemia	______Yes_______No	Reflux	______Yes_______No
Stroke	______Yes_______No	Ulcerative Colitis	______Yes_______No
COPD	______Yes_______No	Heart Attack	______Yes_______No
Sleep Apnea	______Yes_______No	Anxiety	______Yes_______No
High Cholesterol	______Yes_______No	Diabetes	______Yes_______No
High Blood Pressure	_______Yes_______No	Hyperthyroidism	______Yes_______No
Heart Disease	______Yes_______No	Congestive Heart Failure	______Yes_______No

Other conditions not listed ____

_____Yes_____No Have you ever had a mammogram? If yes, date and location of last mammogram

____

_____Yes_____No Do you have children? Total # of pregnancies____ How old were you when your first child was born?_____

_____Yes_____No Did you breastfeed your children?

_____Yes_____No Do you have menstrual periods? How old where you when they began? ____________________

_____Yes_____No Is there a chance you are pregnant?

_____Yes_____No Have you ever had a breast biopsy or cyst aspiration? If yes, which breast?________________

_____Yes_____No Have you ever been diagnosed with breast cancer? If yes, which breast? _________________

At what age were you diagnosed? _________

______Yes____No Have you ever been diagnosed with Ovarian Cancer? If yes, at what age?_______

_____Yes_____No Have you been diagnosed with Colon or Endometrial/Uterine/Pancreatic Cancer?(Circle one/both)
If yes, at what age(s)?___________

_____Yes_____No Have you ever had nipple discharge?

_____Yes_____No Do you have breast pain or tenderness?

_____Yes_____No Are you taking birth control pills or shots?

_____Yes_____No Are you taking hormones? How long have you taken hormones? ________________________

_____Yes_____No Are your nipples inverted? Left________________Right _______________

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Family History

Does any member of your family have problems with any of the following?

Father		**Mother**	
Heart Disease	_____Yes_____No	Heart Disease	_____Yes____No
High Blood Pressure	_____Yes_____No	High Blood Pressure	_____Yes____No
Asthma	_____Yes____No	Asthma	_____Yes____No
Stroke	_____Yes____No	Stroke	____Yes____No
Diabetes	____Yes____No	Diabetes	____Yes____No
Deceased	____Yes____No	Deceased	____Yes____No
Cause of death________________________		Cause of death______________________	

Family Cancer History

Please consider the following relatives from both your Mother and Father's side of the family:

Father, Mother, sisters, brothers, your children, Grandparents, Aunts, Uncles, Great Grandparents, Great Aunts, Uncles

Have any of these relatives been diagnosed with any of the following cancers?

____Yes_____No Breast Cancer? Who?____ Age? ________
____ ________
____ ________

____Yes_____No Colon Cancer? Who?____ Age? ________
____ ________
____ ________

____Yes_____No Ovarian Cancer? Who?____ Age? ________
____ ________
____ ________

____Yes_____No Endometrial Or Uterine Cancer? Who?____ Age? _________
____ _________
____ _________

____Yes_____No Other Cancers? Please Explain
____
____
____
____
____

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Social History

Do you use tobacco products of any kind? _____Yes _____No

Approximately how often?___________________________________

Do you consume alcohol? _______Yes ______No

Approximately how often? __________________________________

Review of Systems

(Please circle all of the following symptoms you have recently had)

General Health:

Fever Chills Unintentional weight loss Sleeping problems Fatigue Dizziness Weight Gain

Lung or Respiratory:

Frequent non- productive cough Frequent productive cough Shortness of breath

Heart and Circulation:

Blacking out or fainting Chest pain Irregular heartbeat Swelling of ankles Chest discomfort
Trouble breathing on exertion Calf or leg pain

GI:

Abdominal pain Diarrhea Bloating Constipation Heartburn Nausea Vomiting Loss of appetite

GU:

Blood in urine Painful urination

Skin/Nails:

Abscess Cyst Ingrown toenail Keloid Lesion Mole Skin tag Tumor/mass Ulcer Wart
Breast mass/pain

Endocrine:

Excessive hunger Excessive thirst Excessive sweating Increased/decreased energy level Unwanted weight change

Please list any other symptoms you currently have that are not listed above____

____

REVISION HISTORY

Author	Revision Date	Page #	Summary of Changes
Towana Gipson	09/07/2016	1	Header and Footer added
			.