

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 PRIM	ARY 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		

Reference: ISO 9001: 2015, Formulation date: 9/16, Revision: 9/16 Approved by: T.Gipson, RN, Clinic nurse manager, Page 1 of 4

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Medical History



Have you ever been diagnosed with the following problems?

Liver Disease	YesNo	Emphysema	Yes	No				
Asthma	YesNo	HIV	Yes	No				
Kidney Disease	YesNo	Seizures	Yes	No				
Anemia	YesNo	Reflux	Yes	No				
Stroke	YesNo	Ulcerative Colitis	Yes	No				
COPD	YesNo	Heart Attack	Yes	No				
Sleep Apnea	YesNo	Anxiety	Yes	No				
High Cholesterol	YesNo	Diabetes	Yes	No				
High Blood Pressure	YesNo	Hyperthyroidism	Yes	No				
Heart Disease	YesNo	Congestive Heart Failure	Yes	No				
Other conditions not	Other conditions not listedYesNo Have you ever had a mammogram? If yes, date and location of last mammogram							
YesNo	Do you have children? Total # o	f pregnancies How old were you wher	ı your first ch	ild was born?_				
YesNo	No Did you breastfeed your children?							
YesNo	Do you have menstrual periods? How old where you when they began?							
YesNo	Is there a chance you are pregnant?							
YesNo	YesNo Have you ever had a breast biopsy or cyst aspiration? If yes, which breast ?							
YesNo Have you ever been diagnosed with breast cancer? If yes, which breast? At what age were you diagnosed?								
YesNo								
YesNo								
	If yes, at what age(s)?							
YesNo	Have you ever had nipple discharge?							
YesNo	Do you have breast pain or tenderness?							
YesNo	Are you taking birth control pills or shots?							
YesNo	Are you taking hormones? How long have you taken hormones?							
YesNo	Are your nipples inverted? LeftRight							

OCH CENTER FOR BREAST HEALTH PATIENT HISTORY AND PHYSICAL



Family History

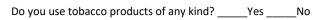
Does any member of your family have problems with any of the following?

Father		Mother					
Heart Disease	resNo	Heart DiseaseYesNo					
High Blood Pressure	YesNo	High Blood PressureYesNo					
Asthma	YesNo	AsthmaYesNo					
Stroke	YesNo	StrokeYesNo					
Diabetes	YesNo	DiabetesYesNo					
Deceased	YesNo	DeceasedYesNo					
Cause of death		Cause of death					
-	ives from both your Mot	ancer History ther and Father's side of the family:					
		rents, Aunts, Uncles, Great Grandparents, Great Aunts, Uncles					
Have any of these relatives been d	iagnosed with any of the	e following cancers?					
YesNo Breast Cancer?		Age?					
YesNo Colon Cancer?	Who?	Age?					
YesNo Ovarian Cancer	? Who?	Age?					
YesNo Endometrial Or Uterine Can		Age?					
YesNo Other Cancers?	Please Explain						

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Social History



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	Unintentiona	al weight loss	Sleeping pr	oblems	Fatigue	Dizziness	Weight Gain	
Lung or R	espiratory:								
Frequent	non- produ	ictive cough	Frequent p	roductive coug	n Shor	tness of breat	h		
Heart and	l Circulatio	n:							
Blacking c	out or fainti	ng Chest	pain Irre	gular heartbeat	Swelli	ng of ankles	Chest disco	mfort	
Trouble b	reathing or	exertion	Calf or leg pa	in					
GI:									
Abdomina	al pain	Diarrhea	Bloating	Constipation	Heartbu	urn Nause	ea Vomitin	g Loss of a	appetite
GU:									
Blood in u	irine P	ainful urinatio	on						
Skin/Nails	5:								
Abscess Breast ma	Cyst iss/pain	Ingrown toe	enail Kelo	id Lesion	Mole	Skin tag	Tumor/mass	s Ulcer	Wart
Endocrine	:								
Excessive change	hunger	Excessive th	irst Exces	sive sweating	Increas	ed/decreased	energy level	Unwanted w	/eight

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

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REVISION HISTORY

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