TEXAS HEALTH CARE
Breast Surgical Oncology

PATIENT HISTORY

label space

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Name_____ Today's Date _____
Date of Birth _____ Occupation _____
For what problem did you come to the doctor today? _____
_____
First noticed when_____Location_____Severity _____
Any associated symptoms _____
Doctor who sent you here _____ Family Doctor? ❒ OB/GYN? ❒
Are you allergic to anything? _____
Could you be pregnant?_____ Date of last menstrual period _____
Medicines you take (include aspirin, over-the-counter, vitamin supplements):

Name of the medicine	Dosage	For what purpose?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Problems you have (Please check all that apply):

❒ Excessive Bleeding	❒ Heart Problems	❒ Arthritis	❒ Clotting or bleeding disorder
❒ Heart Attack (MI)	❒ Diabetes	❒ Sickle Cell Disease	❒ Heart Surgery
❒ Asthma	❒ Depression/Anxiety	❒ High Blood Pressure	❒ Stroke
❒ Autoimmune Disorder	❒ High Cholesterol	❒ Ulcer	❒ Kidney Problems
❒ Thyroid Disease	❒ TB	❒ HIV or AIDS	❒ Emphysema
❒ Anemia	❒ Hepatitis or Jaundice	❒ Cancer (What kind? _____)	

❒ Adverse reaction to Anesthesia (What reaction? _____)
Previous operations/surgery and dates _____

Removal of uterus? _____ Removal of ovaries? _____
Have you been hospitalized not involving surgery _____
_____
Do you smoke?_____ For how long?_____ How Much?_____
Serving per day: Coffee_____ Tea_____ Caffeinated drinks_____ Chocolate _____
Present alcohol use:_____ Past alcohol use: _____
Family History: Has anyone in your family had any of the following? If "yes" indicate that person's relation to you, otherwise, list "no":
High Blood Pressure _____ Heart attack _____
Heart Failure _____ Stroke _____
Diabetes _____ Anything that runs in the family _____
Cancer (who and what kind?) _____

Breast Health Information

Please list any previous breast problems OR breast surgery: _____
_____
_____
Family members with breast cancer? ❒ No ❒ Yes (if yes, please list approximate age below)
First degree relatives: _____ Sister(s) _____ Mother _____ Daughter(s) _____
Mother's side: Grandmother _____ Aunt(s) _____ Cousin(s)_____ Men _____
Father's side: Grandmother _____ Aunt(s) _____ Cousin(s)_____ Men _____

Age when menstrual periods began_____ How many children do you have? _____
How many times have you been pregnant?_____ Age at delivery of first live child _____
Have you ever taken birth control pills? _____ Approximate dates: _____
Have you ever taken hormones? _____ What kind? _____ Approximate dates_____
Do you now take hormones? _____ What kind? _____ Dose _____
How long have you taken it? _____

Review of Systems

Do you currently have any of these symptoms? (check all that apply)

CONSTITUTIONAL SYMPTOMS:
- ❑ Fever
- ❑ Infection
- ❑ Night sweats
- ❑ Fatigue
- ❑ Weight loss

Other general problems:

_____

EYES:
- ❑ Blindness
- ❑ Glaucoma
- ❑ Retinal problems
- ❑ Cataracts

Other eye problems:

_____

EARS, NOSE, MOUTH, AND THROAT:
- ❑ Earaches
- ❑ Ringing in the ear
- ❑ Sensation of spinning
- ❑ Nose bleed
- ❑ Sinus problems
- ❑ Sore tongue
- ❑ Dental problems
- ❑ Bleeding gums
- ❑ Sore throat
- ❑ Painful swallowing
- ❑ Difficulty swallowing
- ❑ Change in voice

Other head or neck problems:

_____

CARDIOVASCULAR:
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Ankle swelling
- ❑ Leg pain when walking
- ❑ Rheumatic fever
- ❑ Fast heart beats
- ❑ Irregular heart beats
- ❑ Heart murmur
- ❑ Congestive heart failure
- ❑ Myocardial infarction
- ❑ Pulmonary embolism
- ❑ Thrombophlebitis
- ❑ Venous or Arterial thrombosis

Other heart problems:

_____

RESPIRATORY:
- ❑ Chronic cough
- ❑ Coughing up blood

Other lung problems:

_____

GASTROINTESTINAL:
- ❑ Decreased appetite
- ❑ Difficulty swallowing
- ❑ Hiatal hernia
- ❑ Esophagitis
- ❑ Nausea/vomiting
- ❑ Vomiting blood
- ❑ Gastritis
- ❑ Liver disease
- ❑ Gallstones
- ❑ Crohn's disease
- ❑ Cirrhosis
- ❑ Ulcerative colitis
- ❑ Black stools
- ❑ Bloody stools
- ❑ Hemorrhoids
- ❑ Diverticulitis

Other stomach or intestinal problems:

_____

GENITOURINARY:
- ❑ Kidney stones
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Passing urine at night
- ❑ Kidney infection
- ❑ Bladder infection
- ❑ Enlarged prostate

GYNECOLOGY(women only):
- ❑ Uterine polyps
- ❑ Abnormal pap smear
- ❑ Endometriosis
- ❑ Abnormal vaginal bleeding

Last Gyn exam date:

_____

MUSCULOSKELETAL:
- ❑ Osteoporosis
- ❑ Artificial joints
- ❑ Disc problems

SKIN
- ❑ Psoriasis
- ❑ Skin cancer
- ❑ Previous biopsies
- ❑ Melanoma

Other skin problems:

_____

NEUROLOGICAL:
- ❑ Slurred speech
- ❑ Weakness on one side
- ❑ Seizures
- ❑ Migraines
- ❑ Temporary eye blindness
- ❑ Headaches

Other brain or nerve problems:

_____

PSYCHIARIC:
- ❑ Depression
- ❑ Drug/Alcohol Abuse

Other psychiatric problems:

_____

ENDOCRINES:
- ❑ Hypoglycemia
- ❑ Goiter/thyroid surgery
- ❑ Heat/cold intolerance

Other endocrine problems:

_____

HEMATOLOGIC/LYMPHATIC:
- ❑ Enlarged lymph nodes
- ❑ Hemophilia
- ❑ Easy bruising
- ❑ Blood clotting problems

Other blood or lymph node problems:

_____

Ethnicity: ❑ African-American ❑ White ❑ Hispanic ❑ Asian ❑ Native American ❑ Other

Patient Signature _____ **Date** _____

Physician Signature _____ Date _____

Attending Physician Signature _____ Date _____

Release of Information
Request

Patient's Name_____ Maiden/Former Name:_____

Patient's Address:_____

City, State, Zip:_____

Birth Date:_____ Social Security #:_____

Home Phone:_____ Other Phone:_____

I, Authorize: To Release to:

_____ _____

_____ _____

_____ _____

The following information may be released:
- ☐ Entire Medical Record
- ☐ Specific Record From_____to_____
- ☐ Immunizations
- ☐ Billing Record
- ☐ Only_____

Purpose of Disclosure:
- ☐ Medical Care
- ☐ Insurance
- ☐ Attorney
- ☐ Other_____

I consent to the release of the indicated sensitive, legally protected records (patient to initial).
Mental Health Records....._____
HIV or AIDS ....._____
Chemical Dependency....._____

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Signature of Patient or Representative: Date:

_____ _____
Printed Name: Relationship to Patient:

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.