OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

BREAST SURGERY CLINIC

1836 E 15th St, Tulsa, OK 74104
918.585.5658

PATIENT HISTORY

PLEASE PRINT CLEARLY

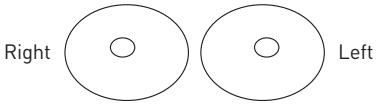
Date _____

Name _____ Check One: ☐ Female ☐ Male Age _____

Date of Birth _____ Have you seen Dr. Smith in the past? ☐ Yes ☐ No Year: _____

BREAST HISTORY

Do you have a **breast lump**, **thickening**, or **tissue changes**? ☐ No ☐ Yes
If yes, describe the problem and mark the area of your concern on the diagram:



_____

☐ No ☐ Yes Do you have any **nipple discharge**? *If yes, describe:*_____

☐ No ☐ Yes Do you have any **breast pain**? *If yes, describe:*_____

☐ No ☐ Yes Have you been previously treated for **breast cancer**? *If yes, when and at what facility?* _____

☐ No ☐ Yes Have you ever had a **biopsy** of your breasts? *If yes, when and where was the procedure performed?*_____

☐ No ☐ Yes Have you ever had a **mammogram**? *When and where was the procedure performed?*_____

☐ No ☐ Yes Have you ever had an **abnormal mammogram**? *If yes, describe:* _____

☐ No ☐ Yes Do you perform monthly self breast examinations?

☐ No ☐ Yes Do you have **breast implants**? *If yes, when:* _____ Specify bra size: _____

MENSTRUAL HISTORY

☐ No ☐ Yes If you have a period, is it regular? ☐ No ☐ Yes Have you ever taken birth control pills?

☐ No ☐ Yes Have you experienced menopause? *If yes, at what age?*_____

☐ No ☐ Yes Have you had a hysterectomy (removal of the uterus)? ☐ No ☐ Yes Do you still have ovaries?

☐ No ☐ Yes Are you on any hormone replacement therapy (prescription or non)?

If yes, what kind? _____ *How long have you been taking it?* _____

Age at first period _____ Date of last menstrual period_____ Age at first childbirth _____

Number of pregnancies _____ Number of live births _____ Number of miscarriages/abortions _____

SOCIAL HISTORY

☐ No ☐ Yes Do you smoke or use tobacco products? *If yes, how many packs per day?* _____ *How many years?* _____

☐ No ☐ Yes Do you use alcohol? *If yes, how many servings per day?* _____

☐ No ☐ Yes Do you use street drugs? *If yes, which one(s) and how often?* _____

☐ No ☐ Yes Do you currently endure any unusual stress in your life? _____

☐ No ☐ Yes Are you frequently exposed to dangerous or toxic chemicals? *If yes, which one(s) and how often?* _____

Including yourself, how many people currently reside in your home? _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is the highest level of education you have completed?_____

What is your average daily level of exercise? _____

Caffeine Intake *(Servings Per Day)* Coffee _____ Tea _____ Cola _____ Chocolate _____

Name _____ Check one: ☐ M ☐ F Age _____ Date of Birth _____ Height _____ Weight _____

PAST MEDICAL HISTORY — CHECK ALL THAT APPLY

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer, type:_____
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Lactose Intolerance
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Suicide Attempts
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers

List any other illness: _____

PAST SURGICAL HISTORY

Year	Hospital	Reason for Treatment and Outcome

Pharmacy Name: _____ **Phone:** _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dosage	Medication	Dosage

LIST ALL ALLERGIES

Substance	Reactions

Name _____ Check one: ☐ M ☐ F Age _____ Date of Birth _____ Height _____ Weight _____

FAMILY HISTORY

Have any of your family members been diagnosed with breast cancer?

Family Member	Maternal	Paternal	Age at Diagnosis	
				Unilateral Both
				Unilateral Both
				Unilateral Both
				Unilateral Both
				Unilateral Both

LIST ANY OF YOUR FAMILY MEMBERS WHO HAVE BEEN DIAGNOSED WITH THESE ILLNESSES:

Illness	Family Member	Maternal	Paternal	Age at Diagnosis
Ovarian Cancer				
Uterine Cancer				
Endometrial Cancer				
Colon Cancer				
Prostate Cancer				
Melanoma				
Pancreatic Cancer				
Heart Disease				
Diabetes				
Glioblastoma				

Have you undergone genetic testing in the past? ☐ Yes ☐ No
If yes, where and when was genetic testing performed?

_____

Have any of your family members undergone genetic testing? ☐ Yes ☐ No ☐ Unknown
If yes, where and when was genetic testing performed?

_____

Do you have any particular ethnic background that may influence your genetic risk? ☐ Yes ☐ No
If yes, please specify:

_____

Name _____ Check one: ☐ M ☐ F Age _____ Date of Birth _____ Height _____ Weight _____

Please check here and sign if all negative ☐ Patient Signature _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW OR IN THE PAST

Past	Now	General	Past	Now	Cardiovascular	Past	Now	Muscle/Joint/Bones Pain/Weakness/Numbness in:
		Chills			Chest Pain			Arms
		Dizziness			Heart Murmur			Back
		Fainting			High Blood Pressure			Feet
		Fatigue			Irregular Heartbeat			Hands
		Fever			Low Blood Pressure			Hips
		Forgetfulness			Palpitations			Legs
		Loss of Sleep			Poor Circulation			Neck
		Sudden Weight Loss			Rapid Heartbeat			Shoulders
		Sweats			Swelling of Ankles	**Past**	**Now**	**Skin**
Past	**Now**	**Eye**			Varicose Veins			Changes in Moles
		Blurred Vision	**Past**	**Now**	**Gastrointestinal**			Hives
		Crossed Eyes			Bloating			Itching
		Double Vision			Bowel Changes			Rash
		Vision Flashes			Constipation			Scars
		Vision Halos			Diarrhea			Sores that won't heal
Past	**Now**	**ENT/Mouth**			Excessive Hunger	**Past**	**Now**	**Hematologic**
		Bleeding Gums			Gas			Bruise Easily
		Difficulty Swallowing			Hemorrhoids	**Past**	**Now**	**Endocrine**
		Ear Discharge			Indigestion			Diabetes
		Earache			Nausea			Excessive Thirst
		Hay Fever			Poor Appetite			Thyroid Problems
		Hoarseness			Rectal Bleeding	**Past**	**Now**	**Psychiatric**
		Loss of Hearing			Stomach Bleeding			Anxiety
		Nosebleeds			Vomiting			Depression
		Ringing in Ears			Vomiting Blood			Nervousness
		Sinus Problems	**Past**	**Now**	**Genitourinary**	**Past**	**Now**	**Neurologic**
		Sore Throat			Blood in Urine			Headache
Past	**Now**	**Respiratory**			Frequent Urination			Numbness
		Coughing up Blood			Lack of Bladder Control			Stroke
		Persistent Cough			Painful Urination			
		Shortness of Breath						
		Wheezing						