

DEKALB SURGICAL ASSOCIATES PATIENT QUESTIONNAIRE - BREAST

Name _____ Age _____ Today's Date _____

Your Primary Physician _____ Office Phone _____ Did they refer you? Y or N

If no, which physician / person referred you to us? _____ Office Phone _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

The main reason for your visit is: Breast lump, abnormal mammogram, breast pain, nipple drainage, other: _____

How many term pregnancies (children)? _____ Other pregnancies (miscarriages/abortions)? _____ Age at 1st preg _____

First menstrual period _____ yrs old. Have you used birth control pills/ estrogen or other hormone pills? Yes/ No If yes, # of yrs _____

Previous breast biopsies? Yes/No _____ Date of last mammogram _____ Relatives with breast (BR) or ovarian (OV) cancer? Mother (BR) (OV) Sister (BR) (OV) Grandmother (BR) (OV) Other _____ (BR) (OV)

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU

High blood pressure **Prior heart attack** **Heart failure** **Chronic lung disease** **Diabetes** on pills on Insulin

General: Your weight? _____ Unintended weight loss or gain, fatigue, fevers / chills, sweats, heat intolerance, insomnia

Eyes: Loss of vision, cataracts, cataract surgery, glaucoma, intolerance of bright lights

Cardiovascular: High cholesterol, angina / chest pain, bypass surgery / angioplasty, irregular heartbeat / palpitations, poor circulation

Respiratory: Emphysema, asthma, sleep apnea, shortness of breath, chronic cough, hoarseness

Gastrointestinal: Ulcers, acid reflux / heartburn, nausea, vomiting, gallstones, constipation, diarrhea, blood in stool, abdominal pain chronic acute/recent, difficulty swallowing, hepatitis, cirrhosis, date of last colonoscopy _____

Urinary: Kidney failure/ dialysis, kidney stones, burning or blood in urine, urinary infections in the past, last PSA date _____

Musculoskeletal: Arthritis in knees hips hands _____, hip knee replacement, gout, osteoporosis

Gyn: Vaginal bleeding / discharge, Pelvic pain Last period, or date of menopause _____, Last Pap date _____

Skin: Previous skin cancers, melanoma, recent change in a mole, eczema, psoriasis

Neurologic: Epilepsy / seizure disorder, stroke (year _____), headaches, numbness, weakness, dizziness, jaw pain

Psychiatric: Schizophrenia, depression, anxiety, irritability, other mental illness

Hematologic: Blood clots, deep vein thromboses (DVT), varicose veins, anemia, easy bruising / bleeding, on Coumadin, +HIV

Endocrine: Overactive or underactive thyroid, thyroid mass, on Prednisone or other steroid

Cancer Survivor: Lung, breast, colon, prostate, ovarian, other _____ Yr of diagnosis: _____

Do you: Smoke? Not since _____ No 1/2 1 2 pks/day, **Drink alcohol?** None 1-2 drinks/day > 2/day

Do you: Use any recreational drugs? Yes No **Exercise regularly?** Yes No

Family history: Father Alive Deceased Medical problems _____

Mother Alive Deceased Medical problems _____

How many Brothers _____ Sisters? _____ Family members with: High blood pressure, heart disease, diabetes, cancer

Please provide additional information on any circled items or other medical problems: _____

Previous surgeries with dates : _____

Allergies: Penicillin, iodine dye, aspirin, codeine, sulfa, latex rubber, other _____

Medications (including nonprescription medications, please provide dosage and frequency if known): _____

Vital Signs (nurse will complete) T _____ BP _____ P _____

Patient Signature Date
I understand that the above medical information will be used in making treatment decisions and I attest that it is accurate to the best of my knowledge.

Physician signature Date
I have reviewed the above medical information with the patient.