**VANDERBILT BREAST CENTER** **AGE:_____**
**INITIAL PATIENT HISTORY FORM**

**REFERRING PHYSICIAN:_____**

**TODAYS COMPLAINTS**:_____
_____

**FAMILY HISTORY OF BREAST CANCER (CIRCLE ):**

MOTHER FATHER GRANDMOTHER AUNT

SISTER COUSIN OTHER

**OTHER FAMILY CANCER**: **WHO**_____
**WHAT TYPE**: _____

**NEW BREAST COMPLAINTS:**
A NEW LUMP THAT CAN BE FELT R / L WHEN DID YOU NOTICE THE LUMP:_____
BLOODY NIPPLE DISCHARGE R / L HOW LONG?_____
NON-BLOODY DISCHARGE R / L COLOR_____ HOW LONG?_____
IMPLANT PROBLEMS R / L DESCRIBE:_____
PAIN IN THE BREAST R / L HOW LONG?_____
MONTHLY SELF EXAM?_____ OTHER CHANGES?_____
LAST MAMMOGRAM DATE:_____

**PREVIOUS BREAST PROCEDURES: CIRCLE LEFT OR RIGHT**
_____ CYST ASPIRATION YR_____ R / L
_____ SURGICAL BIOPSY YR_____ R / L
TYPE:_____
_____ NEEDLE BIOPSY YR_____ R / L
TYPE:_____
_____MASTECTOMY YR_____ R / L
_____LUMPECTOMY YR_____ R / L
_____RECONSTRUCTION YR_____ R / L
TYPE:_____

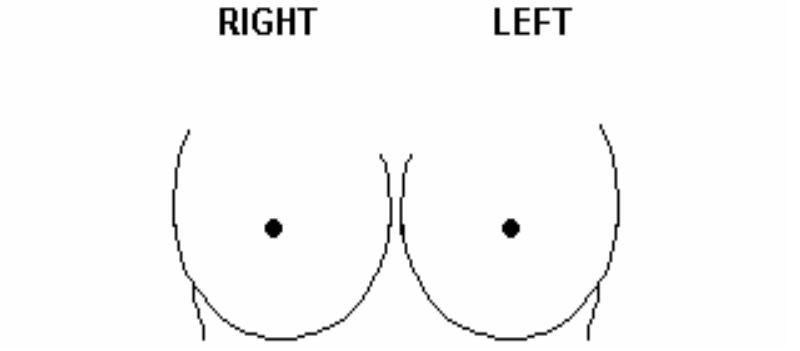
**TREATMENTS (CURRENT OR PAST):** CHEMOTHERAPY _____ DATE :_____ END:_____
TYPE OF CHEMO THERAPY:_____
RADIATION _____ DATES:_____ END:_____
HORMONAL THERAPY (TAMOXIFEN, AROMASIN ETC.)_____ DATE_____

NUMBER OF PREGNANCIES?_____ NUMBER OF LIVE BIRTHS?_____NUMBER OF MISCARRIAGES/ABORTIONS?_____
AGE OF FIRST PERIOD_____ DATE OF LAST PERIOD_____
AGE AT FIRST CHILDBIRTH_____ DID YOU BREASTFEED?_____ HOW LONG? _____ AGE AT MENOPAUSE_____
TOTAL YEARS OF ORAL CONTRACEPTIVE USE:_____ TOTAL YEARS OF HORMONE REPLACEMENT THERAPY:_____

**FOR OFFICE USE ONLY:**
MAMMOGRAM: VANDERBILT_____ OUTSIDE_____

ULTRASOUND: VANDERBILT _____ OUTSIDE_____
**EXAM:**

**PLAN:**



# MEDICAL HISTORY

**PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING:**

**General:** Weight loss, weight gain, fever, chills or night sweats, fatigue

**Skin:** Change in texture/color of moles or skin, hives, rash, itching, scaling or bruising.

**Ears, Eyes, Nose, Mouth and Throat:** Pain, double vision, blurred vision, deafness, nose bleeds, ringing of ears or hoarseness.

**Cardiovascular:** Palpitations, chest pain, shortness of breath with activity, swelling in legs or feet

**Respiratory:** Cough, production of sputum, asthma or coughing up blood.

**Gastrointestinal:** Abdominal pain, nausea, vomiting, jaundice, diarrhea, constipation, bloody stools, tarry stools, vomiting blood

**Genitourinary:** Kidney problems, bladder problems, pain with urination, inability to urinate, frequency of urination, blood in urine

**Musculoskeletal:** Deformities of bones/ joints, limitations of movement.

**Neurological:** Paralysis, weakness, involuntary movements, numbness, fainting, migraine headaches, loss of coordination

**Emotional:** Anxiety, depression, hallucinations

**Endocrine:** Change in appetite, goiter, excessive thirst, diabetes

**Hematological/ Lymphatic:** Swollen lymph nodes, bleeding disorders

**Immunologic:** Immune disorders or HIV

**Breast:** Trauma, lumps, pain, nipple discharge or infections, skin changes

**ALL CURRENT MEDICATIONS AND DOSAGES**

_____
_____
_____
_____
_____

**MEDICATION ALLERGIES (LIST REACTIONS)**

_____
_____
_____
_____
_____

**OPERATIONS & YEAR OF PROCEDURE**

_____
_____
_____
_____
_____

**MEDICAL PROBLEMS**

_____
_____
_____
_____
_____

**FAMILY HISTORY**

KIDNEY DISEASE LIVER DISEASE
HEART DISEASE LUNG DISEASE
HYPERTENSION DIABETES
CANCER

**SOCIAL HISTORY (CURRENT OR PAST):**

TOBACCO USE_____HOW MANY?_____
ALCOHOL USE_____HOW MUCH?_____
CAFFEINE USE_____HOW MUCH?_____

OCCUPATION:_____ PEOPLE IN YOUR HOUSEHOLD:_____