Medical History Intake Questionnaire

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Date of Consultation:_____

Patient Name: Age: Date of Birth:

What condition or problem brings you to our office today?_____

_____

How long has this been bothering you?_____

Have you had treatment for this previously? If yes, what treatment, where, and when?_____

_____

Who referred you to our practice?_____

Physician Care

Primary Care Doctor: _____

Referring Doctor: _____

General or Breast Surgeon: _____

Oncologist: _____

Dermatologist: _____

Other: _____

How would you describe your health status (excellent, good, fair, poor)?_____

What is your **Height**?_____ **Weight**?_____

Past Medical History	yes		yes		yes
Allergies		Cerebrovascular accident		Hypertension	
Anemia		COPD		Irritable bowel disease	
Angina		Coronary Artery Disease		Liver disease	
Anxiety		Crohn's Disease/Colitis		Migraine headaches	
Arthritis		Depression		Myocardial infarction/Heart Attack	
Asthma		Diabetes		Osteoarthritis	
Atrial fibrillation/Arrhythmia		Well controlled?		Osteoporosis	
Benign Prostatic Hypertrophy		Gallbladder disease		Peptic Ulcer Disease	
Blood Clots		GERD		Renal Disease	
Cancer		Hepatitis C		Seizure Disorder	
Type?		Hyperlipidemia		Other	

Have you ever had radiation therapy/treatment? If so, when?_____

Have you ever had a blood transfusion?_____

Have you ever been diagnosed or treated for a psychiatric condition? If so, what and when?_____

_____

Past Surgical History	yes/year		yes/year		yes/year
Angioplasty		Cholecystectomy		ORIF/Fracture repair	
w/stent		Colectomy		Pacemaker placement	
Appendectomy		Colostomy		Small bowel resection	
Arthroscopy knee		Gastric Bypass		Thyroidectomy	
Back Surgery		Hernia repair		Tonsillectomy	
Coronary Bypass/CABG		Hip replacement		Prostate biopsy	
Carpal Tunnel Release		Lasik		TURP/Prostate resection	
Cataract Extraction		Liver biopsy		Vasectomy	

Other Surgical Procedures_____

Have you had any cosmetic surgeries and/or procedures? If so, what and when?_____

_____

Have you had skin or wound healing problems? (Please describe)_____

Do you scars tend to hypertrophy or keloid? (Please describe)_____

Medications (include vitamins and herbal supplements)			**Allergies (please list)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	
_____	_____	_____	

Social History

Do you smoke? If yes, how much?_____

Did you ever smoke? If yes, when did you quit?_____

Do you drink alcohol? How often?_____

Have you ever used recreational or street drugs? Are you currently?_____

Do you exercise? (Please describe)_____

Are you dieting or trying to lose weight? (Please describe)_____

Occupation?_____

Hobbies/Sports?_____

	Living?	Condition/diagnosis	Age	Cause of death	
Family History: Relation					
Mother					
Father					
Review of Systems	yes		yes		yes
Chills		Cough		Dizziness	
Fatigue		Shortness of breath		Headaches	
Fever		Chest pain		Memory Loss	
Malaise		Claudication		Seizures	
Weight gain		Edema		Anxiety	
Weight loss		Abdominal pain		Depression	
Eye problems		Diarrhea		Insomnia	
Hearing loss		Constipation		Contact Allergy	
Nasal drainage		Nausea		Skin lesions	
Sinus pressure		Vomiting		Back or joint pain	
Sore throat		Urinary problems		Bleeding or Bruising tendencies	
Vision changes		Other?			

What pharmacy do you use?_____

Phone number and Address_____

Patient Signature:_____ Date:_____

PLEASE MAKE SURE YOU SIGN AND DATE

Cosmetic Surgery Patients

What cosmetic surgery or procedure(s) currently interest you?_____

_____

Have you had any cosmetic surgery and/or procedures before? (Please describe)_____

_____

If so, were you satisfied with the results?_____

Breast Surgery Patients (Reconstructive and Cosmetic)

What breast surgery are you interested in having? (Reconstructive, augmentation, lift, augmentation w/ lift, other)_____

_____

Have you had any breast surgery or procedure(s) prior? (Please describe)_____

_____

What brassiere size do you currently wear?_____

What size would you like to have?_____

Have you had any breast problems? Which breast?_____

lumps/masses_____

nipple discharge_____

skin or nipple retraction_____

size change_____

neck or back pain_____

bra strap pain_____

irritation to skin under breast_____

other_____

When was your last mammogram?_____

Were there any abnormalities?_____

_____

Have you had any other breast diagnostic tests (ultrasound, MRI, biopsy)? (Please describe)_____

_____

Do you have any family history of breast cancer? (Who and age of diagnosis)_____

_____

Breast Cancer Reconstruction Patients

Who is your breast surgeon (surgical oncologist)?_____

Who is you medical oncologist?_____

Have you had radiation therapy?_____