

# COMPREHENSIVE BREAST CARE OF SAN DIEGO

3075 Health Center Drive Suite 102

San Diego, CA 92123

T: 858.637.7888 F: 858.637.7883

## PATIENTS MEDICAL HISTORY

\_\_\_\_\_  
**LAST NAME**                      **FIRST**                      **MI**                      **D.O.B.**                      **DATE**

**REFERRING PHYSICIAN:** \_\_\_\_\_

### CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began.

	Problem	Date of onset
1		
2		
3		

### GENERAL HEALTH AND HABITS

Characterize your current health status:     Excellent     Very Good     Average     Poor

**Exercise**

Do you exercise regularly?     Yes    No   

Type of exercise(s) \_\_\_\_\_

**History of Smoking**     Yes    No   

Specify: \_\_\_\_\_

How many per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

What do you/did you smoke?     Cigarettes     Pipe    \_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week

Cigars Other (specify) \_\_\_\_\_

When did you quit smoking? \_\_\_\_\_

**Nutrition**

Vitamin/Mineral Supplements \_\_\_\_\_

Your appetite:     Excellent     Good     Fair     Poor

Are there foods you avoid (or limit) for health reasons? Yes     No   

**Alcohol/Beverages**

Estimate the amount of alcohol you drink regularly:

\_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week

Did you formerly drink alcohol but have

permanently stopped?     Yes    No   

Estimate the amount of caffeinated beverages (Coffee, Tea, Cola):

you drink per day \_\_\_\_\_ Glasses, Cups or Cans.

### PAST MEDICAL AND SURGICAL HISTORY

List the chronologically all your surgeries, including the nature of each operation and where and when performed. (Be accurate and complete. Consult family, friends, physicians, etc).

	Operation	Hospital and City	Date
1			
2			
3			
4			

Have you ever been seriously injured? (If so give details and date)

List	Reason for hospitalization	Hospital and City	Date
1			
2			
3			

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## CURRENT MEDICATIONS

List all medications you are now taking.

Name of medicine	Strength	How often taken	When began taking

## ALLERGIES

Please list allergies to medications and reaction:


## PERSONAL HISTORY

Where were you born?

Have you ever lived or traveled extensively abroad?

Yes  No

If so, give details:

Have you ever worked in the field of medicine, in any capacity, including volunteer, aide, clerk, or technician?

What is the highest level of education you have attained?

What inhaled chemicals or particles are you exposed to at your place of work? \_\_\_\_\_

List the areas you have lived chronologically, giving dates:

	Area	From	To
1			
2			
3			

List your past occupations chronologically, giving dates:

	Occupation	From	To
1			
2			
3			

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## PERSONAL HISTORY CONTINUED

Have any blood relatives ever had any of the following? (If so, indicate relationship)

Abnormal bleeding or clotting \_\_\_\_\_

“Heart Attack” \_\_\_\_\_

Alcoholism \_\_\_\_\_

Psychiatric disease or suicide \_\_\_\_\_

A disease which “runs in the family” \_\_\_\_\_

## FAMILY HISTORY OF CANCER

	RELATION				
	MOTHER	FATHER	BROTHERS	SISTERS	CHILDREN
AGE OF DIAGNOSIS					
<b>TYPE OF CANCER</b>					
BREAST					
OVARIAN					
PANCREATIC					
STOMACH					
MELANOMA					
OTHER CANCER					

## GENERAL FAMILY HEALTH

RELATION	AGE IF ALIVE	AGE OF DEATH	STATE OF HEALTH/CAUSE OF DEATH
MOTHER			
FATHER			
BROTHERS/ SISTERS			
CHILDREN			

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## REVIEW OF SYSTEMS

<b>BREAST</b>	Yes	No	<b>NEUROLOGICAL</b>	Yes	No
Have you ever had tumors, cysts, or other breast disease?			Have you ever had:		
Do you experience nipple discharge?			Stroke		
Do you experience persistent breast pain?			Paralysis or muscular weakness		
Have you ever had a breast biopsy?			Neurological disease		
Have you ever had breast surgery?			Frequent or recurrent headaches		
When was your last pap smear?			Loss of consciousness		
<b>GYNECOLOGIC OBSTETRIC</b>	Yes	No	Convulsions and or seizures		
If you are still menstruating, <b>provide date of your last period</b>			Head injury		
If you have stopped menstruating, provide <b>age of your last period</b>			Difficulty with coordination		
Have you had a hysterectomy?			Tremor or abnormal movements		
Age at first pregnancy			Difficulty walking		
How many times have you been pregnant (including miscarriages)			Difficulty speaking		
How many live births?			Double vision or loss of vision		
How many years total have you taken hormones or birth control pills?			Numbness		
<b>RESPIRATORY</b>	Yes	No	Difficulty with memory		
Have you ever had any of the following? If so, indicate date.			Dizziness		
Pleurisy			<b>MOOD</b>	Yes	No
Tuberculosis skin test			Have you recently experienced:		
Tuberculosis (infection or contact)			Severe anxiety, panic, or phobias		
Pleurisy			Excessive fatigued		
Tuberculosis skin test			Depression		
Tuberculosis (infection or contact)			Have you ever:		
Asthma (wheezing)			Had a nervous breakdown or required psychiatric care		
Chronic bronchitis			Had a drug or alcohol problem		
Emphysema			Been involved in domestic violence		
Other lung trouble			<b>ENDOCRINOLOGY</b>	Yes	No
Exposure to dangerous dust or fumes			Have you ever had any of the following? If so, indicate date		
Excessive snoring			Hormone problems		
Chest pain			Thyroid disease		
Abnormal chest X-ray			Diabetes		
Have you ever coughed up blood?					
Do you often cough?					
Do you often cough up sputum?					

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## REVIEW OF SYSTEMS CONTINUED

<b>HEMATOLOGY AND ONCOLOGY</b>	Yes	No	<b>EYES AND EARS</b>	Yes	No
Have you ever had:			Have you ever had:		
Anemia			Glaucoma		
Bleeding or bruising tendency			Other major eye diseases		
Cancer or tumor			Deafness		
X-ray or radiation treatment			Abnormal noises in the ear		
Do you practice breast or testicular self exam?			<b>ALLERGY AND IMMUNOLOGY</b>	Yes	No
<b>CIRCULATORY</b>	Yes	No	Have you ever had:		
Have you ever had any of the following? If so, indicate date			Asthma		
Chest pain			A reaction to penicillin		
Heart trouble			A reaction to aspirin		
Heart attack (coronary)			A reaction to any other drug (Specify)		
Angina pectoris			Date and type of immunization :		
High cholesterol			Tetanus-Diphtheria (every 10 years)		
High blood pressure			<b>JOINTS</b>	Yes	No
Blackouts			Have you ever had any of the following? If so, indicate date.		
Racing of heart			Muscle Pain		
Rheumatic fever			Back pain		
Abnormal cardiogram			Joint pain/swelling		
Swelling of your ankles			Osteoarthritis		
Have you ever taken heart or water pills?			Gout		
			Have you been diagnosed with rheumatoid arthritis?		
<b>URINARY</b>	Yes	No	<b>CUTANEOUS</b>	Yes	No
Have you ever had			Have you ever had:		
Kidney disease or nephritis			Skin rashes		
Protein or albumin in urine			Skin cancer		
Do you have discomfort passing urine?			<b>DIGESTIVE</b>	Yes	No
Blood or pus in urine			Do you regularly have:		
Kidney stones			Poor appetite		
Urinary infection			Trouble swallowing		
<b>DIGESTIVE</b>	YES	NO	Heartburn		
Vomiting blood			Regurgitation of food or bile		
Parasitic infection			Nausea or vomiting		
Black or tarry stools			Constipation		
Yellow jaundice			Diarrhea		
Liver problems or hepatitis			Has there been any change in your bowel function in the past 6 months?		
Gallbladder problems or stones			Hiatal or esophageal hernia		
Persistent diarrhea or colitis			Duodenal or gastric ulcer		
Diverticulitis					