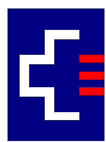


INOVA HEALTH SYSTEM

Patient Name: ______________________________

MRN: ______________________________

DOB: ______________________________

INOVA BREAST CARE CENTER

New Patient Medical History

Today's date::___________

Reason for Visit:____

Do you have any particular concerns about your breast health? ______________________________

____

Medical History:

Do you have a history of:

	Yes	No		Yes	No		Yes	No
Heart Attack?			Kidney Problems?			Hepatitis?		
Stroke?			Liver Problems?			HIV/AIDS?		
High Blood Pressure?			Seizures?			TB?		
Diabetes?			Psychiatric disorder?			Radiation Therapy?		
Asthma?			Anemia?			Other medical problems?		
Lung Disease?			Bleeding Disorder?					
Sleep Apnea?			Cancer					

Previous Surgeries:

____
____
____
____
____
____

Previous Hospitalizations:

____
____
____
____
____
____

Allergies:

Do you have any allergies?

□No □Yes

If yes, please list your allergies & describe your reaction

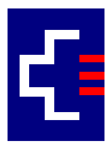
____
____
____

Current Medications:

Medication	Dose	How many times per day?	Reason for taking

MD Reviewed__________________________________ Date ___________

□ Dr. Bruce □ Dr. Cocilovo □ Dr. Cohen □ Dr. De La Cruz □ Dr. Edmiston □ L. Hatcher, NP □ M. Kisiel, NP



INOVA HEALTH SYSTEM

Patient Name: ______________________________

MRN: ______________________________

DOB: ______________________________

New Patient Medical History (continued)

Gynecologic history:

Age at first period: ______ LMP: ________ Age of menopause: _______

Total # of pregnancies______ Total # of births_______

How old were you when you had your first baby? ________

Bra size___________

Date of most recent mammogram? _______________

Have you experienced:

Nipple discharge: Y N

Breast Pain: Y N

Have you ever used:

Birth Control Pills Y N If Yes, # of Years used : _________

Hormone Replacement or Fertility Drugs: Y N

Did you Breast Feed: Y N

Other Breast History:____

Family History:

Have any of your **relatives** ever had:

			Who?	at what age?
Breast cancer?	N	Y		
Ovarian cancer?	N	Y		
			Who?	**What kind of Cancer?**
Any other cancer?	N	Y		

Ashkenazi Jewish ancestry? N Y

What is your Ethnic Background? ____

Social History:

Marital Status: S M D W

Occupation: ____

Do you drink alcohol? □ No □Yes (how often?____________________________)

Do you smoke? □ Never □ Previously, but quit (when?__________________)

□ Yes, currently (how many years?__________________________)

Do you use recreational drugs? □No □Yes (describe:____________________________)

MD Reviewed_________________________________ Date ___________

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INOVA HEALTH SYSTEM

INOVA BREAST CARE CENTER

Patient Name: ______________________________

MRN: ______________________________

DOB: ______________________________

New Patient Medical History (continued)

Review of Systems:

Please circle any health problems in the following areas:

CONSTITUTIONAL	HEENT	CARDIOVASCULAR	RESPIRATORY
Fever Chills Night Sweats Fatigue Weight change	Vision problems glasses / contacts Double vision Cataracts Glaucoma Hearing problems Ringing in ears Sinus pain Congestion Sore throat Dental problems Difficulty swallowing Pain with swallowing Hoarseness	Chest pain Palpitations Heart murmur Edema Pain with walking Pain in legs at rest	Cough Sputum (bloody?) Difficulty breathing Pain with breathing Wheezing Snoring
GASTROINTESTINAL	**GENITOURINARY**	**MUSCULOSKELETAL**	**SKIN**
Poor appetite Heartburn Regurgitation Nausea Vomiting Abdominal pain Diarrhea Constipation Bloody stool	Urinary pain Urinary urgency Urinary incontinence Blood in urine	Muscle aches Swelling Joint pain Bone pain Weakness	Rash Itchiness Dryness Moles or skin lesions Nail changes
NEUROLOGIC	**PSYCHIATRIC**	**ENDOCRINE**	**HEMATOLOGIC**
Headache Seizures Numbness Tingling Dizziness Tremor Decreased coordination Memory loss Confusion	Anxiety Depression Sadness Hopelessness	Heat or cold intolerance High blood sugar Thyroid problems Hair loss	Easy bruising/bleeding Sickle cell disease Thalassemia History of blood transfusion Lymph node problems
GYNECOLOGIC	**BREAST**	**OTHER**	
Vaginal bleeding Vaginal discharge Pelvic pain	Breast pain Breast mass Nipple discharge		

Patient signature:______________________________ Date:________

MD Reviewed______________________________ Date ___________

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