MEDICAL QUESTIONNAIRE

NAME: _____ DOB: ___/___/_____ AGE: ____

If you do not understand a question or you do not feel comfortable in answering a question, leave it blank and go to the next question. Some questions may not apply to you.

DATE OF LAST MAMMOGRAM: ___/___/_____ REFERRING MD: _____
DATE OF LAST BREAST ULTRASOUND: ___/___/_____ PRIMARY MD: _____

PAST MEDICAL HISTORY		ILLNESSES	DATE DISCOVERED
YES _____	NO _____	High Blood Pressure	___/___/_____
YES _____	NO _____	Diabetes	___/___/_____
YES _____	NO _____	Heart problems	___/___/_____
YES _____	NO _____	Cancer (Type: _____)	___/___/_____
YES _____	NO _____	Stroke	___/___/_____
YES _____	NO _____	Blood clots	___/___/_____
OTHER: _____			___/___/_____

CURRENT MEDICATIONS

NAME	AMOUNT	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HERBAL, VITAMIN OR NUTRITIONAL THERAPIES

NAME	AMOUNT	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

MEDICATION OR SUBSTANCE	DESCRIBE REACTION OR SYMPTOM
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST SURGERIES

(CHECK THOSE THAT YOU HAVE HAD)

	Date		Date
_____ C-Section	___/___/_____	_____ Left Breast Biopsy	___/___/_____
_____ Removal of ovary	___/___/_____	_____ Right Breast Biopsy	___/___/_____
_____ removal of uterus	___/___/_____	_____ Tubal Ligation	___/___/_____
_____ Other _____			___/___/_____

OB-GYN HISTORY

Age at first menstrual period _____
How many pregnancies have you had? _____
How many children have you given birth to? _____
Age of first delivery _____
Date of last menstrual period ___/___/_____
Date of last Pap Smear ___/___/_____
Have you taken estrogen or female hormones in the last 10 years? _____
Date Started? ___/___/_____
Date Stopped? ___/___/_____

SOCIAL HISTORY

Occupation _____
Marital Status _____ Never Married _____ Married _____ Divorced _____ Widowed
Where do you currently live? City: _____ State: _____
Do you smoke cigarettes now? _____ Yes _____ No
Have you smoked in the past? _____ Yes _____ No
When did you start? Date: ___/___/_____
When did you quit? Date: ___/___/_____
Do you drink alcohol? _____ Yes _____ No Quantify: _____

FAMILY HISTORY

Is there anyone with breast cancer in your blood family? If so, list them by their relation to you, their age, and when the cancer was found.

Relation:	Age when cancer was discovered:	Age at death:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any women with ovarian cancer in your blood family? If so, list them by their relation to you, their age, and when the cancer was found.

Relation:	Age when cancer was discovered:	Age at death:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Father's information _____
Is your father alive? _____ Yes _____ No
If yes, how old is he? _____
If not, how old was he when he passed away? _____
What was the cause of death? _____

Mother's information _____
Is your mother alive? _____ Yes _____ No
If yes, how old is she? _____
If not, how old was she when she passed away? _____
What was the cause of death? _____

Brothers:

Alive	Age	Illnesses
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____

Sisters:

Alive	Age	Illnesses
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____
___ Yes ___No	_____	_____

Children:

Age	Sex	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Race:
___ American Indian/Alaskan Native
___ Asian
___ Native Hawaiian/Pacific Islander
___ Black or African American
___ White

Ethnicity:
___ Hispanic or Latino
___ Not Hispanic or Latino

	HEALTH REVIEW (last 3 months)	YES	NO
GENERAL:			
	Weigh change, greater than 5lbs?	_____	_____
	Persistent fatigue:	_____	_____
SKIN:			
	Any new skin rashes, lumps, or bumps?	_____	_____
	Hot flashes?	_____	_____
EYES:			
	Recent vision change?	_____	_____
MOUTH:			
	Sore throat?	_____	_____
	Sore mouth?	_____	_____
NECK:			
	New lumps?	_____	_____
	Thyroid problem?	_____	_____
LUNGS:			
	Cough?	_____	_____
	Shortness of breath?	_____	_____
HEART:			
	Chest pain?	_____	_____
	Ever been told you had a heart murmur?	_____	_____
	Abnormal EKG?	_____	_____
GASTROINTESTINAL:			
	Nausea or vomiting?	_____	_____
	Constipation?	_____	_____
	Change in bowel habits?	_____	_____
	Change in appetite?	_____	_____
	Any liver or colon problems?	_____	_____
GENITOURINARY:			
	Problems with urination?	_____	_____
	Vaginal dryness?	_____	_____
JOINTS/EXTREMITIES:			
	Any bone or joint pain or stiffness?	_____	_____
	Arm swelling / lymphedema?	_____	_____
	Ever had a blood clot?	_____	_____
NEUROLOGIC:			
	Have you ever had a seizure?	_____	_____
	Do you have weakness of an arm, leg, or other part of your body?	_____	_____
BLOOD:			
	Any history of anemia or blood disorder?	_____	_____
PSYCHOLOGICAL:			
	Have you ever been treated for depression or anxiety?	_____	_____

PLEASE GIVE THIS FORM TO THE MEDICAL ASSISTANT WHEN YOUR VITAL SIGNS (BLOOD PRESSURE, ETC) ARE TAKEN.