Dr. Christine M. Gresik
New Patient Medical History

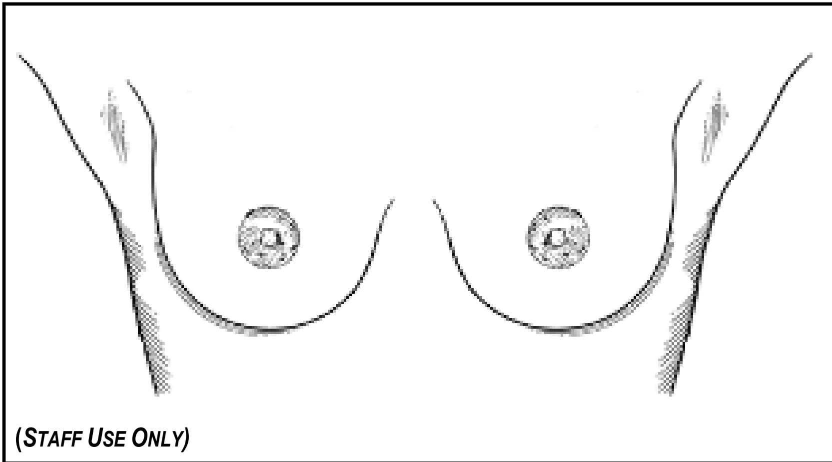
Consult Date: ______/______/_____

NAME (*LAST, FIRST, MI*):______________________________________ Date of Birth: ______/______/______

Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Separated ❐ Widowed

Sex: ❐ Female ❐ Male

Referring Physicians: ____



(*STAFF USE ONLY*)

Please describe briefly, <u>in your own words</u>, the date of onset of your current problem or illness, any symptoms you have experienced, and the dates of any test and/or treatment(s).

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<u>Reason for Seeking Care</u>

1. Have you been diagnosed with breast cancer recently or are you here to seek treatment for breast cancer?

❐ Yes ❐ No

2. What was the problem that occurred which prompted you to seek medical care? **Check all that apply.**

❐ abnormal mammogram
❐ lump in breast found by self
❐ lump in breast found by clinician
❐ inverted nipple
❐ armpit or axillary mass
❐ bloody discharge from nipple
❐ breast pain or discomfort
❐ other (*please specify* ____)

At approximately what date did this symptom (including abnormal mammogram) become apparent to you? [ ]

<u>Gynecologic History</u>

3. At what age did you have your first period? [ ]

4. How many times have you been pregnant? [ ]

5. How many live births have you had? [ ]

   a. If you have children, what was your age at your first time full term pregnancy? [ ]

6. Have you ever breast fed? ❐ Yes ❐ No

   a. If yes, how many months (in total) have you breast fed? [ ] months

   b. What is your breast cup size? [ ]

7. Have you had a menstrual period within the last six months?

❒ No
❒ Yes, natural menstrual periods or menstrual periods on birth control pills

a. If yes, when was your last menstrual period? _____/______/_____

b. If no, at what age did you stop having menstrual periods? [ ]

c. If no, why did you stop having periods? ***Check One.***

❒ pregnancy and/or breast feeding
❒ natural menopause
❒ hysterectomy with ovaries left in
❒ hysterectomy with both ovaries removed
❒ hysterectomy, unsure about ovaries
❒ both ovaries removed, no hysterectomy
❒ chemotherapy/radiation therapy/hormone therapy
❒ medical condition(s) associated with ovarian failure
❒ hormone replacement therapy (not including HRT for cancer therapy)
❒ other (*please specify* ________________________________)

8. Have you ever used, or do you currently use, '**post-menopausal**' hormone replacement therapy? **Do NOT include birth control pills**.

❒ No, never ❒ Yes, currently ❒ Yes, in the past When did you last use hormones (month/year)? _______/________

a. If yes, how many total years (or months) have you used hormone replacement? [ ] months / years ***(Please circle one)***

9. Do you use, or have you ever used, birth control pills? ❒ No, never ❒ Yes, currently ❒ Yes, in the past

If yes, how many total years? _______ When did you last use birth control pills (year)? __________

10. Have you ever used fertility drugs? ❒ Yes ❒ No

FAMILY HISTORY

Please include only blood relatives, both living and deceased.

12. How many sisters do you have? [ ] 13. How many brothers? [ ]

14. How many daughters? [ ] 15. How many sons? [ ]

16. Were any of your grandparents of Ashkenazi Jewish descent (from France, Germany, Eastern Europe, or Russia)?
❒ Yes ❒ No ❒ Do not know

17. Do you have any blood related family relatives who have been diagnosed with cancer? If yes, please use the chart below to indicate their relationship to you, the type of cancer they have, their age at diagnosis, and their current age if alive or their age at death. Please provide your best estimate for ages.

Blood Relative	Maternal or Paternal	Cancer type	Age at Diagnosis	Current Age if Alive	Age at Death if Passed
SAMPLE: *Mother*	*M*	*breast cancer*	*63*	*75*	

SMOKING AND ALCOHOL HISTORY

18. Have you ever or do you currently smoke?
    - ❒ Yes, but only in the past
    - ❒ Yes, currently (if yes, # packs/day ______________)
    - ❒ No, never

19. Have you ever or do you currently drink alcohol?
    - ❒ Yes, but only in the past
    - ❒ Yes, currently
    - ❒ No, never

20. How many alcoholic beverages (beer, wine, mixed drinks, etc.) do you consume weekly? ***Check one.***
    - ❒ none
    - ❒ socially
    - ❒ rarely, less than 1 drink per week
    - ❒ 1-4 drinks per week
    - ❒ 5-9 drinks per week
    - ❒ > 10 drinks per week

PHYSICAL ACTIVITY

21. Which option below best describes your level of physical activity OVER THE PAST WEEK? ***Check one.***
    - ❒ fully active, able to carry on all usual activities without restriction
    - ❒ restricted in strenuous activity; can walk; able to carry out light housework
    - ❒ can walk and take care of self; up more than ½ day
    - ❒ need some help in taking care of self, spend more than ½ day in bed or chair
    - ❒ cannot take care of self at all and spend all my time in bed/chair

PATIENT BACKGROUND INFORMATION

22. What is your current employment status? ***Check one***.
    - ❒ homemaker
    - ❒ employed 32 hours or more per/week
    - ❒ employed less than 32 hours per week
    - ❒ full-time student
    - ❒ on medical leave
    - ❒ disabled
    - ❒ unemployed and/or seeking work
    - ❒ retired
    - ❒ other (*please specify* ________________________)

PAST SURGERY/OPERATIONS

23. Please list in chronological order (include type, reason, and approximate year):

____

____

PAST BREAST BIOPSIES

24. How many previous breast biopsies have you had, including any needle core and surgical excisional biopsies? ☐
DO NOT include cyst aspirations or the recent biopsy leading up to your current breast cancer diagnosis.

Please list these biopsies below:

Year	Which Breast (Right or Left)?	Needle Core Biopsy or Excisional Biopsy?	Diagnosis (please circle the result of your biopsy)
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS

MEDICAL HISTORY

25. Please list any **medical conditions** for which you are currently being treated or were treated for in the past:

____

____

<u>REVIEW OF SYSTEMS</u>
(CHECK ALL THAT APPLY)

<u>GENERAL</u>:
❒ Fever ❒ Night Sweats ❒ Generalized Weakness ❒ Weight Loss
❒ Chills ❒ Fatigue ❒ Change in Appetite

<u>EYES</u>:
❒ Wear Contacts/Glasses ❒ Cataracts ❒ Glaucoma ❒ Change in Vision
❒ Irritation ❒ Yellowing of the eyes

<u>EARS/NOSE/THROAT</u>:
❒ Hearing Loss ❒ Earaches ❒ Nasal Congestion ❒ Nose Bleeds ❒ Snoring
❒ Hoarseness ❒ Change in voice

<u>LUNGS</u>:
❒ Cough ❒ Phlegm ❒ Coughing up Blood ❒ Asthma ❒ Wheezing
❒ Difficulty in breathing with exertion ❒ Emphysema ❒ Chronic Bronchitis ❒ Shortness of Breath

<u>HEART/VASCULAR</u>:
❒ Chest Pain ❒ Chest pressure/discomfort ❒ Palpitations ❒ Irregular Heartbeat
❒ Fainting or Near-fainting ❒ Difficulty breathing when lying flat ❒ SOB/Coughing at Night ❒ Swelling of Legs

<u>GASTROINTESTINAL</u>:
❒ Difficulty or pain with swallowing ❒ Reflux symptoms ❒ Vomiting ❒ Dark or Bloody Stools ❒ Constipation
❒ Nausea ❒ Change in Bowel Habits ❒ Diarrhea ❒ Abdominal Pain ❒ Vomiting Blood

<u>GENITOURINARY</u>:
❒ Frequent urination ❒ Waking up at night to urinate ❒ Urinary hesitancy or retaining urine ❒ Painful urination
❒ Urinary incontinence ❒ Decreased urine stream ❒Blood in the urine ❒ Vaginal/Penile Discharge

<u>SKIN/HAIR/NAILS</u>:
❒ Rash ❒ Itching ❒ Skin lesions ❒ Dry Skin ❒ Change in Skin Color ❒ Change in Mole

<u>HEMATOLOGIC/LYMPHATIC</u>:
❒ Bruise Easily ❒ Bleed Easily ❒ Persistent swollen glands or lymph nodes

<u>MUSCULOSKELETAL</u>:
❒ Muscle Aches/Pain ❒ Joint pain ❒ Stiff Joints ❒ Neck Pain ❒ Back Pain

<u>HEAD AND NERVOUS SYSTEM</u>:
❒ Migraines or severe headaches ❒ Seizure/Epilepsy ❒ Speech problems ❒ Coordination Problems
❒ Trembling/tremors ❒ Fainting/Black Outs ❒ Dizziness ❒ Memory problems
❒ Loss of sensation/numbness ❒ Problems walking ❒ Weakness ❒ Tingling or burning in hands/feet

<u>PSYCHIATRIC/SOCIAL</u>:
❒ Abusive relationship ❒ Bipolar ❒ Sleep Disturbance ❒ Anxiety ❒ Depression ❒ Feeling of despair

<u>ENDOCRINE</u>:
❒ Poor/slow wound healing ❒ Fertility or hormone problems ❒ Cold intolerance ❒ Thyroid disease