**Medical History Form**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Consultation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**

**Check all that apply and list details/diagnoses**

**□ Heart Attack/Heart Disease □ Congestive Heart Failure □ Diabetes □ High Blood Pressure □ Emphysema**

**□ COPD □ Thyroid Problems □ Asthma □ Stroke □ Heart Failure □ Hepatitis B □ Hepatitis C □ AIDS/HIV**

**□ Coagulation or Bleeding Disorder (you may take Plavix or Coumadin for)**

**□ Sleep Apnea □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Medical Problems and Details:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY: Including Defibrillators, Pacemakers, or Stents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Operation** | **Date** | **Operation** | **Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, aspirin or blood thinners.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Times per Day** | **Medication** | **Dose** | **Times Per Day** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**CENTRAL TEXAS SURGICAL ASSOCIATES**

**ALLERGIES or REACTIONS: □ None □ Latex**

|  |  |
| --- | --- |
| **Medication** | **Reaction or Side Effect** |
|  |  |
|  |  |
|  |  |
|  |  |

**FAMILY HISTORY:**

**Please check all that apply.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Condition** | **Mom** | **Dad** | **Sister** | **Brother** | **Daughter** | **Son** | **Other** |
| **Anesthesia Problem** |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |
| **Bleeding Problem** |  |  |  |  |  |  |  |
| **Breast Cancer** |  |  |  |  |  |  |  |
| **Colon Cancer** |  |  |  |  |  |  |  |
| **Melanoma** |  |  |  |  |  |  |  |
| **Thyroid Cancer** |  |  |  |  |  |  |  |
| **Parathyroid Cancer** |  |  |  |  |  |  |  |
| **Prostate Cancer** |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |
| **Heart Attack** |  |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |
| **Leukemia** |  |  |  |  |  |  |  |
| **Lupus** |  |  |  |  |  |  |  |
| **Lymphoma** |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |
| **Vascular Disease** |  |  |  |  |  |  |  |
| **Living** |  |  |  |  |  |  |  |
| **Deceased** |  |  |  |  |  |  |  |

**SOCIAL HISTORY**

**Tobacco Use**

Cigarettes: **□** Never □Current Smoker: Packs/day\_\_\_\_\_\_ # of Years \_\_\_\_\_\_\_\_

**□** Quit: Date \_\_\_\_\_\_\_\_\_\_\_\_\_ How many years did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_

Other Tobacco:

**□** Pipe **□** Cigar **□** Snuff **□** Chew

**Alcohol Use**

**□** No **□** Yes: # of Drinks/Week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CENTRAL TEXAS SURGICAL ASSOCIATES**

Is your current Illness/problem work related? \_\_\_\_yes \_\_\_\_no

Please Indicate Below If You Are Currently Experiencing Any of These Symptoms:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General, Constitutional** |  |  | **Musculoskeletal** |  |  |
| Does your job require heavy lifting | no | yes | Joint Pain | no | yes |
| Recent Weight Gain | no | yes | Back Pain | no | yes |
| Recent Weight Loss | no | yes | Muscle Pain or Cramps | no | yes |
| Fever | no | yes | Difficulty in Walking | no | yes |
| Fatigue | no | yes |  |  |  |
|  |  |  | **Skin and Breasts** |  |  |
| **Eyes and Vision** |  |  | Change in Skin Color | no | yes |
| Wear Glasses or Contact Lenses | no | yes | Varicose Veins | no | yes |
|  |  |  | Breast Pain/Tenderness | no | yes |
| **Ears, Nose, Throat** |  |  | Breast Lump | no | yes |
| Swollen Lymph Nodes | no | yes | Breast Discharge | no | yes |
| Trouble Swallowing | no | yes | Rash or itching | no | yes |
|  |  |  | Healing Problems | no | yes |
| **Heart and Cardiovascular** |  |  |  |  |  |
| Shortness of Breath with activity or exertion | no | yes | **Neurological** |  |  |
| Chest Pains | no | yes | Frequent Headaches | no | yes |
| Sudden Heartbeat Changes/Irregular Heartbeat/Palpitations | no | yes | Light Headed or Dizzy | no | yes |
| Swelling of Feet, Ankles, Hands | no | yes | Seizures | no | yes |
| Murmurs | no | yes | Tremors | no | yes |
|  |  |  |  |  |  |
| **Respiratory** |  |  | **Psychiatric** |  |  |
| Persistent/Frequent Coughing | no | yes | Memory Loss or Confusion | no | yes |
| Shortness of Breath | no | yes | Nervousness/Anxiety | no | yes |
| Asthma or Wheezing | no | yes | Depression | no | yes |
|  |  |  |  |  |  |
| **Gastrointestinal** |  |  | **Endocrine** |  |  |
| Loss of Appetite | no | yes | Excessive Thirst | no | yes |
| Change in Bowel Movements | no | yes | Excessive Urination | no | yes |
| Nausea or Vomiting | no | yes |  |  |  |
| Frequent Diarrhea | no | yes | **Genitourinary** |  |  |
| Painful Bowel Movements or Constipation | no | yes | Frequent Urination | no | yes |
| Blood in Stool | no | yes | Difficulty with Urination | no | yes |
| Abdominal/Stomach Pain | no | yes | Blood in Urine | no | yes |
| Difficulty Swallowing | no | yes | Change in Force or Strain with Urination | no | yes |
| Heartburn | no | yes | Recurrent UTI | no | yes |
| Hemorrhoids | no | yes |  |  |  |
| Rectal Bleeding | no | yes |  |  |  |
|  |  |  |  |  |  |

**CENTRAL TEXAS SURGICAL ASSOCIATES**

**CURRENT SYMPTOMS CONTINUED**

|  |  |  |
| --- | --- | --- |
| **Hematological/Lymphatic** |  |  |
| Slow to Heal After Cuts | no | yes |
| Easily Bruise or Bleed | no | yes |
| Anemia | no | yes |

**Breast Patient History**

How many children have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your age when first child was born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you breastfeed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at last menstrual cycle (If menopausal)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset of last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of prior breast biopsies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_\_\_\_\_\_\_\_\_ If so, what year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Implants? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take hormone replacement therapy? \_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you do regular breast self exams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

List family members with breast or ovarian cancer and their relationship to you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_