

Medical History Form

Date: _____ Height _____ Weight _____ Age: _____
 Name: _____ Date of birth: _____
 Family doctor: _____ OB/GYN doctor: _____

Why are you here today? _____

GYNECOLOGY/BREAST HISTORY

Date of last Mammogram _____ (prior to this current study) Bra size _____

Age at first period/menstrual cycle _____ Date of last menstrual period _____

Age when 1st child was born: _____ Did you breast feed any of your children? Yes No

of pregnancies _____ #of deliveries/children _____ #miscarriages _____ # abortions _____

Have you taken birth control pills/injections? No Yes # of years _____

Age at menopause _____ Did you take hormone replacements? No Yes: # of years _____
 If yes, please list names: _____

Have you had your ovaries removed? No Yes: one both Reason: _____

Have you had a hysterectomy (removal of uterus)? No Yes Reason: _____

Have you ever had? _____ Abnormal vaginal bleeding _____ Abnormal Pap smear _____ Uterine Fibroids
 _____ Endometriosis _____ Breast lumps _____ Breast pain

_____ Nipple discharge Right Left What color is discharge? _____

_____ Cyst aspiration/removal of fluid Right Left Dates: _____

_____ Breast biopsy/mass removal Right Left Dates: _____
 Results: _____ Fibroadenoma _____ Fibrocystic changes _____ Other: _____

_____ Lumpectomy(cancer only) Right Left Dates: _____

_____ Mastectomy Right Left Dates: _____

Breast Cancer in your family? No Yes Who: _____
 Age at diagnosis: _____

Has there been BRCA (breast cancer gene) testing in your family? No Yes: _____

Ovarian Cancer in your family? No Yes Who: _____
 Age at diagnosis: _____

Name: _____

MEDICAL HISTORY

| Condition | Yes | No | Condition | Yes | No |
|---------------------|-----|-----|--------------------|-----|-----|
| Stroke | ___ | ___ | Diabetes | ___ | ___ |
| High blood pressure | ___ | ___ | Kidney disease | ___ | ___ |
| Heart disease | ___ | ___ | Sleep Apnea | ___ | ___ |
| Uterine fibroids | ___ | ___ | HIV/AIDS infection | ___ | ___ |

Other illness: _____

Cancer type: _____

Have you ever had any radiation treatments? Yes _____ No _____ Name of Doctor: _____
If yes, from _____ to _____ Area of body treated _____

Have you ever had any chemotherapy treatments? Yes _____ No _____
If yes, from _____ to _____ Name of Oncologist: _____

SURGERY /OPERATIONS/HOSPITALIZATIONS/PROCEDURES

Please list in chronological order (use back if needed). Check here if no prior surgery _____
Date Operation Hospital/Doctor

SOCIAL HISTORY

Occupation(s): _____
Do you use tobacco products? Yes ___ No ___ # of years _____ When did you quit: _____
cigarettes/cigars: _____ per day week OR # packs per day: _____
Do you drink alcoholic beverages? Yes ___ No ___ How much _____
Illicit/Illegal drug use: Yes ___ No ___ Last used: _____
Substance used: _____
Do you drink caffeine: coffee, tea, soda, chocolate, iced tea?
Yes ___ No ___ How much/# of servings _____ per day week

FAMILY HISTORY

List any major illness in your family, include diabetes, heart disease, cancer, etc.

Name: _____

List all ALLERGIES (food & medications) _____ check here if NO ALLERGIES

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Have you ever had an adverse (bad) reaction to anesthesia? No Yes (please explain)

MEDICATIONS

| | | | |
|--|-------|-------|------------------|
| Do you take: | Yes | No | If yes, explain: |
| Aspirin regularly | _____ | _____ | _____ |
| Blood thinners (i.e.: Plavix, Coumadin, etc.) | _____ | _____ | _____ |
| Steroids (i.e.: Prednisone, Cortisone, etc.) | _____ | _____ | _____ |
| Hormones (i.e.: Premarin, etc.) | _____ | _____ | _____ |

List all medications, vitamins, herbals, natural remedies
(If you have a list of medications on another form, please provide us with a copy of that form and leave this section blank)

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Check here if you DO NOT take any medications _____

| Name | Dose & # of times per day | Reason for use |
|-----------|---------------------------|----------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |
| 8. _____ | _____ | _____ |
| 9. _____ | _____ | _____ |
| 10. _____ | _____ | _____ |
| 11. _____ | _____ | _____ |

(Use back of page if additional space needed)

Name: _____

Please check all that apply

CONSTITUTIONAL SYMPTOMS

_____ **check here if all are negative**

___ Fever

___ Infection

___ Fatigue

CARDIOVASCULAR/HEART

_____ **check here if all are negative**

___ Coronary artery disease

___ Blood clot in : Leg Lung Artery Vein

___ Heart murmur

___ Irregular heart beats

___ Congestive heart failure

___ Myocardial infarction/heart attack

Other heart problems: _____

RESPIRATORY/LUNG

_____ **check here if all are negative**

___ Pneumonia

___ Asthma

___ Tuberculosis/T.B.

___ Pulmonary Embolism

___ Sleep apnea

___ Emphysema

GASTROINTESTINAL

_____ **check here if all are negative**

___ Liver disease

___ Peptic/Stomach ulcers

___ Cirrhosis

___ Hepatitis: A B C

Other intestinal problems _____

MUSCULOSKELETAL

_____ **check here if all are negative**

___ Arthritis

___ Osteoporosis

___ Artificial joints

___ Back pain

___ Lymphedema

NEUROLOGICAL

_____ **check here if all are negative**

___ Slurred speech

___ Weakness on one side: Right Left

___ Seizures

___ Stroke

___ Migraines

PSYCHIATRIC

_____ **check here if all are negative**

___ Anxiety

___ Depression

___ Drug/alcohol abuse

___ Bipolar

Other psychiatric problems _____

ENDOCRINE

_____ **check here if all are negative**

___ Goiter/Thyroid surgery

___ Hypoglycemia

Other: _____

HEMATOLOGIC/LYMPHATIC

_____ **check here if all are negative**

___ Anemia

___ Sickle cell disease

___ Enlarged lymph nodes

___ Hemophilia

___ Easy bruising

___ Blood transfusion dates: _____

IMMUNE SYSTEM

_____ **check here if all are negative**

___ AIDS/HIV

Immune disease: _____

The information above is correct to the best of my knowledge AND I have received a copy of "About Our Office" (to be received upon arrive to our office).

Patient signature _____ **Date** _____

Dr. Hampton would like to thank you for completing this important form.