Pre-Assessment Forms

DATE ______________________________ DATE OF BIRTH ___________________ SSN _________________________________

NAME ____ AGE ______________ MARITAL STATUS ___________________

REFERRING PHYSICIAN _________________________________ PCP ____

CHIEF COMPLAINT (CHECK ALL THAT APPLY)

BREAST PAIN ____________ SORENESS __________ TENDERNESS ____________ NIPPLE DISCHARGE __________________

LUMPS __________________ THICKENING __________________ LUMPS UNDER ARMPITS _____________________________

PLEASE DESCRIBE ____

OTHER ____

CURRENT MEDICATIONS

WHAT MEDICATIONS DO YOU TAKE REGULARLY? PLEASE LIST: ____

DO YOU TAKE ASPIRIN OR BLOOD THINNERS? YES _____ NO _____ PLEASE LIST ___________________________________

DO YOU USE DIET, HERBAL PILLS, NASAL SPRAYS? YES _____ NO ____ PLEASE LIST _________________________________

PAST MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK AND DESCRIBE.

DIABETES ___ HIGH BLOOD PRESSURE ___ BLEEDING DISORDERS ___ ANEMIA ____ THYROID DISORDERS __________

VENEREAL DISEASES _______ HEPATITIS ________ HAVE YOU TESTED POSITIVE FOR HIV? YES ________ NO ___________

DESCRIPTION/OTHER ILLNESSES OR DISEASES ____

ALLERGIES

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICINES? YES ________ NO ______

PLEASE LIST ____

GYNECOLOGICAL HISTORY

AGE OF FIRST MENSTRUAL PERIOD ______ FIRST DAY OF LAST PERIOD ____

NORMAL MENSES? YES _____ NO _______ IF NO, PLEASE DESCRIBE ____

PREGNANCIES ___________ DELIVERIES ___________________ YOUR AGE AT FIRST DELIVERY ___________________

BREAST FED? ______________ HOW MANY __________ FOR HOW LONG ____

ARE YOU TAKING OR HAVE YOU TAKEN BIRTH CONTROL PILLS? YES _______ NO ______

PLEASE LIST NAME AND LENGTH OF TIME YOU HAVE BEEN ON CURRENTLY OR IN THE PAST: _________________________

MENOPAUSE? YES ___________ NO _______ IF YES, AT WHAT AGE ____

ARE YOU TAKING OR HAVE YOU TAKEN HORMONES? YES __________ NO ______

PLEASE LIST NAME AND LENGTH OF TIME YOU HAVE BEEN ON CURRENTLY OR IN THE PAST: _________________________

LAST DIAGNOSTIC STUDY

DID YOU HAVE A MAMMOGRAM PRIOR TO YOUR VISIT HERE? YES _____ NO ____ DATE PERFORMED __________________

WHERE WAS IT PERFORMED ____

DID YOU HAVE AN ULTRASOUND PRIOR TO YOUR VISIT HERE? YES _____ NO ______ DATE PERFORMED ______________

WHERE WAS IT PERFORMED ____

IF NOT CURRENT, DATE OF LAST MAMMOGRAM ___________________ BREAST ULTRASOUND _______________________

SURGICAL HISTORY

PREVIOUS BREAST SURGERY? YES ___ NO ___ AGE ___ BREAST BIOPSIES/ASPIRATIONS? YES ____ NO ____AGE ______

HYSTERECTOMY? YES _____ NO _____ AGE ________ OVARIES REMOVED? YES ____ NO ____ AGE __________________

OTHER SURGERIES? ____AGE______________________

FAMILY HISTORY

HISTORY OF BREAST CANCER IN IMMEDIATE FAMILY MEMBERS? YES ______ NO ______ PLEASE DESCRIBE

RELATIONSHIP AND AGE OF ONSET OF BREAST CANCER: ____

HISTORY OF OVARIAN CANCER IN IMMEDIATE FAMILY MEMBERS? YES _____ NO ______ PLEASE DESCRIBE

RELATIONSHIP AND AGE OF ONSET OF OVARIAN CANCER: ____

SOCIAL HISTORY

HOW MUCH DO YOU SMOKE EACH DAY _________________ HOW LONG HAVE YOU SMOKED__________________________

HOW MUCH ALCOHOL DO YOU DRINK___________________ HOW MUCH COFFEE/TEA DO YOU DRINK ___________________

SYSTEMS REVIEW

HAVE YOU BEEN FEELING WEAK ____ TIRED ____ FATIGUED ____ DO YOU HAVE NIGHT SWEATS ___ HOT FLASHES ___

PLEASE EXPLAIN:____

SKIN

HAVE YOU NOTICED ANY NEW OR CHANGING SKIN LESIONS? YES ______ NO ______ RASH? YES _____ NO _____________

PLEASE EXPLAIN:____

HEAD AND NECK (NEUROLOGICAL, PSYCHIATRIC, ENDOCRINE, LYMPHATIC)

FREQUENT HEADACHES ________ FAINTING ______DIZZINESS ______ SEIZURES _______ GLAUCOMA ________________

CONVULSIONS ________ LOSS OF MEMORY ______TROUBLE HEARING________VISUAL CHANGES ___________________

ANXIETY ____ DEPRESSION ____ MOOD SWINGS ___ TROUBLE SWALLOWING ____ FREQUENT SORE THROAT _________

LUMPS OR ENLARGEMENT OF NECK GLANDS ________________ MOUTH SORES/GROWTHS ___________________________

PLEASE EXPLAIN:____

CARDIO-RESPIRATORY

HEART TROUBLE ___________________ ASTHMA __________________ COUGH _____________________________________

SHORTNESS OF BREATH ____________ CHEST PAIN _______________ ARRYTHMIA _________________________________

PLEASE EXPLAIN:____

GASTRO-INTESTINAL

NAUSEA___________ VOMITING __________ ABDOMINAL PAIN __________ BLOOD IN STOOL __________________________

CHANGE IN BOWEL HABIT OR APPETITE ___________________ WEIGHT LOSS IN PAST 6 MONTHS ______________________

PLEASE EXPLAIN:____

GENITO-URINARY

ARE YOU RECEIVING TREATMENT FOR URINARY PROBLEMS? YES________ NO________

PLEASE EXPLAIN:____

EXTREMITIES

TROUBLE WITH CIRCULATION IN: ARMS _____ LEGS______ HISTORY OF PHLEBITIS? YES ____ NO _____ AGE __________

SWELLING OF ANKLES OR FEET ______ VARICOSE VEINS___________ PLEASE EXPLAIN _____________________________

MUSCOLOSKELETAL

DO YOU HAVE ANY PERSISTENT PAIN, SORENESS, TENDERNESS OR DISCOMFORT IN THE NECK, RIBS, BACK, ARMS OR LEGS? YES _____ NO ______ PLEASE EXPLAIN:____

PLEASE PRINT DATE ______________________

NAME __________________________________ AGE _____________ SEX _____________

ADDRESS ____ APT _____________

CITY _____________________________ STATE ____________ ZIP __________________

BIRTHDATE ________________ SS ______________________ MARITAL STATUS ________

PHONE ____________________________ WORK PHONE ____________________________

OCCUPATION ____

EMPLOYED BY ____

EMPLOYERS ADDRESS ____

EMERGENCY CONTACT ____________________________ PHONE ___________________

PERSON RESPONSIBLE FOR BILL ____

WHO REFERRED YOU ____

REASON FOR CONSULTATION ____

MEDICINE ALLERGIES ____

INSURANCE COVERAGE YES NO

NAME OF INSURANCE ____

POLICY NUMBER ____________________________ GROUP NUMBER __________________

NAME OF POLICY HOLDER ____

RELATIONSHIP TO PATIENT ____

DATE OF BIRTH OF POLICY HOLDER ____

I GIVE THE PROVIDERS OF THE BREAST HEALTH CLINIC PERMISSION TO EVALUATE AND TREAT ME.

SIGNATURE

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