Last name: ___________________________ First: _________________________ MI:_____
Date: ________________________________ DOB: __________________________________

Health Information (Circle Yes or No)

General Weight loss Y N Current weight: ______	Weight gain Y N Current height: ______
Skin Symptoms Skin Problems Y N Other: ______________________	Rashes Y N
Ear, Nose, and Throat Earache Y N Hearing Loss Y N Nose Bleeds Y N Other: ______________________	Nasal discharge Y N Mouth sores Y N Throat pain Y N
Bone and Joint Symptoms Joint pain Y N Other: ______________________	Muscle aches Y N
Neurological Difficulty moving arms/legs Y N Fainting Y N Headaches Y N	Do you use a cane, walker, or wheelchair? Y N *if so, do you have frequent falls Y N Other: ______________________
Lymphatic Symptoms Neck pain Y N Lump in neck Y N	Lump in armpit Y N Other: ______________________
Heart Rapid heartbeat Y N High blood pressure Y N	Are you taking blood thinners Y N Other: ______________________
Lung Symptoms Asthma (wheezing) Y N	If Yes, do you use an inhaler? Y N
Endocrine Symptoms Thyroid disorders Y N Other: ______________________	Diabetes Y N
Gastrointestinal Symptoms Decreased appetite Y N Other: ______________________	Heartburn Y N
Bleeding Disorders Do you have bleeding problems Y N Other: ______________________	Do you tend to bruise easily? Y N
Psychological Symptoms Sleep disturbances Y N Anxiety Y N	Depression Y N Other: ______________________
Infectious Diseases HIV/AIDS Y N Hepatitis B Y N	Hepatitis C Y N

Last name: ___________________________ First: _________________________ MI:_____
Date: ________________________________ DOB: __________________________________

List Current Medications: ____

____

Do you take Aspirin? Y N If yes, which MG? 81mg 325 mg

Do you use Goody's Powder? Y N Turmeric? Y N Fish Oil? Y N

List Drug Allergies: (Include Reactions) ____

____

Are You allergic to Iodine/Betadine/Shellfish or MRI Contrast? Circle which applies and list reaction.

____

Do you smoke? Y N History of smoking? Y N Quit Date: __________________________

Do you drink Alcohol? Y N If Yes, how often or # of drinks per week: __________________________

Caffeine Use: Y N How Often? ____

Currently Pregnant? Y N Due Date: ________________________ Currently Nursing? Y N

Have you had any surgeries since your last visit? ____

____

Family History of Breast Cancer? Y N Family Member/Age? _______________________________

Do you have any Ashkenazi or Bahamian decent? ____

Do You have any of the following? Please Circle:

PACEMAKER DEFIBRILLATOR STIMULATOR HEART STENT (If **Yes** to stent, please list date stent was placed and provide your stent card to be copied) _______________________________________

Reason for Today's Visit: ____

New Breast Concerns/Findings? ____

Date of Last Pap Smear: ____

Last Date of Menses? ____

Patient Signature: ____________________________________ Date: __________________________

Physician Signature: ____________________________________ Date:__________________________