

Medical Information and History

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Breast Surgery

AGE _____

OCCUPATION _____

ETHNIC BACKGROUND: _____

HEIGHT _____ WEIGHT _____ BRA SIZE _____

DO YOU SMOKE? _____. ____ PACKS PER DAY FOR ____ YEARS

APPROXIMATE SERVINGS PER DAY:

ALCOHOL: _____

COFFEE/TEA/SODA/CHOCOLATE: _____

DIETARY HABITS: _____

EXERCISE HABITS: _____

PAST OR PRESENT MEDICAL PROBLEMS:

EYES/VISION _____ NO

EARS/NOSE/MOUTH/THROAT _____ NO

GLANDS _____ NO

LUNGS/BREATHING _____ NO

HEART/CIRCULATION _____ NO

STOMACH/DIGESTION _____ NO

URINATION _____ NO

MUSCLES/JOINTS _____ NO

NERVES _____ NO

MENTAL HEALTH PROBLEMS _____ NO

FEVER/CHILLS _____ NO

WEIGHT GAIN/ LOSS _____ NO

MARK SIGNIFICANT PAST OR PRESENT PROBLEMS WITH...

- | | |
|---|---|
| <input type="checkbox"/> STROKE | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> KIDNEY FAILURE |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> EXCESSIVE BLEEDING |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> REACTION TO ANESTHESIA | |
| <input type="checkbox"/> PRIOR HISTORY OF BLOOD TRANSFUSION | |

LIST ANY OTHER MEDICAL PROBLEMS YOU MAY HAVE

OBSTETRIC REVIEW

AGE AT MENARCHE (1ST PERIOD) _____

NUMBER OF PREGNANCIES _____ NUMBER OF BIRTHS _____

AGE AT 1ST TERM PREGNANCY _____

DID YOU BREAST FEED? _____ FOR HOW LONG? _____

DATE OF LAST MENSTRUAL PERIOD: _____

OFFICE USE – DO NOT WRITE BELOW

NAME _____ DATE OF BIRTH _____

REVIEWED _____ RISK ASSESSMENT: 5 YEAR _____ LIFETIME _____ MODEL: _____

LIST PRIOR BREAST SURGERIES WITH DATES

LIST OTHER SURGERIES WITH DATES

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS

HAVE YOU EVER TAKEN CONTRACEPTIVES OR HORMONE REPLACEMENT THERAPY?

HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL OR SURGICAL PROCEDURES? YES NO

MARK IF YOU ARE ALLERGIC TO ...

- | | | |
|-------------------------------------|---------------------------------|--|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> SULFA | <input type="checkbox"/> CODEINE |
| <input type="checkbox"/> MORPHINE | <input type="checkbox"/> IODINE | <input type="checkbox"/> ADHESIVE TAPE |
| <input type="checkbox"/> LATEX | | |

NO KNOWN MEDICAL ALLERGIES

LIST ANY OTHER MEDICAL ALLERGIES _____

FAMILY HISTORY (LIST SIGNIFICANT ILLNESSES)

FATHER _____

MOTHER _____

BROTHERS _____

SISTERS _____

CHILDREN _____

ANY FAMILY HISTORY OF CANCER _____

PATIENT SIGNATURE: _____

DATE: _____