

Medical Information and History

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Breast Surgery

AGE _____

OCCUPATION _____

HEIGHT _____ WEIGHT _____ BRA SIZE _____

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

SERVINGS PER DAY:

ALCOHOL: _____

COFFEE/TEA/SODA/CHOCOLATE: _____

DIETARY HABITS: _____

EXERCISE HABITS: _____

DO YOU HAVE ANY DIFFICULTIES WITH YOUR...

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

FEVER/CHILLS _____ NO

WEIGHT GAIN/ LOSS _____ NO

MARK SIGNIFICANT PAST OR PRESENT PROBLEMS WITH...

STROKE

DIABETES

HEART DISEASE

KIDNEY FAILURE

HIGH BLOOD PRESSURE

ASTHMA

HEPATITIS

THYROID DISEASE

TUBERCULOSIS

EXCESSIVE BLEEDING

CANCER

HIV / AIDS

ANEMIA

SEIZURES

REACTION TO ANESTHESIA

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 _____

REVIEWED _____

DATE OF BIRTH _____

GAIL RISK: 5 YEAR _____ LIFETIME _____

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 ...

PENICILLIN

SULFA

CODEINE

MORPHINE

IODINE

ADHESIVE TAPE

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: _____