NEWPORT BREAST CARE
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Please fill the following health information in order to help you doctor learn about your background. All the information provided will be confidential and will remain filed on your medical chart. Please fill in all the following information to the best of your ability prior to your doctor's visit. Thank you for your assistance.

1. IDENTIFICATION DATA:

Your name ________________________________ Today's date ___/___/___

Referring physician ______________________________ Birthdate ___/___/___

Preferred pharmacy for phoned-in prescriptions ______________________________

2. MEDICINES:

Are you allergic to or have you had a "bad reaction" to any medicines or other substances? ____ YES ____ NO

Medication	*What kind of reaction did it cause?*

Do you take any prescription medications presently? _____ YES _____NO
If so, please list them, including dosage, when you take them and why you take each one below:

Medication	*Dosage*	*When (how many times daily)*	*Why do you take this medicine*

Do you take non-prescription medication? For example: aspirin, Tylenol, anti-inflammatories, laxatives, diet pills, vitamins, antacids or cold remedies? _______ YES _________No
If so, please list, them and why you take each one below:

Medication	*When (how many times a day)*	*Why do you take this medicine*

3. HOSPITALIZATIONS: **Pt. name____________________**

List all your prior hospitalizations:

Illness	*Where*	*Year*

List all your prior surgeries:

Surgery	*Where*	*Year*

4. YOUR HEALTH HISTORY:

Please indicate if your have had any of the following:

Yes	*No*	*Illness*
		Asthma
		Blood Transfusion: When? How many units?
		Heart disease
		High blood pressure
		HIV test for the AIDS virus
		Liver disease, jaundice, hepatitis
		Mental troubles, depression for nervous breakdown
		Pneumonia
		Rheumatic fever
		Serious injury or accident
		Sugar diabetes
		Thyroid gland trouble

		Tuberculosis (TB)
		Uncontrolled bleeding
		Venereal disease (VD) or other sexually transmitted disease
		Cancer

5. FAMILY HEALTH HISTORY:

Please list your family members and their health status:

Family member	Age	If living, present health: Good	Fair	Poor	If not living: Age at death	Cause of death
Mother						
Father						
Brothers						
Sisters						
Sons						
Daughters						

Does anyone in your family have a history of cancer: __________Yes ___________No

Does anyone in your family have a history of a blood disorder: ________Yes _________No

Please indicate the country of origin of your ancestors ________________________________

Are you or a family member of Ashkenazi Jewish descent? _________Yes __________No

Please explain any question above to which you answered yes: ________________________

____

6. SYMPTOMS:

Please check off any of the following symptoms you are experiencing:

______ Dizziness
______ Double vision
______ Severe headaches or migraines
______ Poor eyesight
______ Do you wear glasses
______ Ear or hearing trouble
______ Frequent nose trouble
______ Persistent hoarseness
______ Teeth trouble
______ Do you wear dentures
______ Sore mouth

______ Daily cough – dry
______ Daily cough – sputum/mucus
______ Coughing blood
______ Wheezing
______ Shortness of breath

______ Chest pain with exertion
______ Chest pain at rest
______ Chest pain awakening you from sleep

______ frequent urination
______ Painful urination
______ Blood in urine
______ Trouble starting urine
______ Urinating during the night
______ Losing control of urine

______ Lack of energy
______ Frequent loss of balance
______ Fainting spells (black outs)
______ Convulsions or seizures
______ Tremor
______ Paralysis
______ Numbness
______ Excessive worry
______ Trouble sleeping
______ Depression
______ Crying spells

______Skin rash or itching
______ Joint pains

______ Heart Palpitations
______ Leg vein trouble
______ Leg pain while walking
______ Ankle swelling

______ Trouble swallowing
______ Frequent or severe nausea
______ Frequent or severe heartburn
______ Frequent or severe stomach pain
______ Frequent or severe vomiting
______ Vomiting blood
______ Jaundice
______ Change in bowel habits
______ Change in size of stool
______ Frequent or severe diarrhea
______ Blood in stool
______ Black bowel movement
______ Constipation
______ Hemorrhoids

______ Muscle pain or weakness

______ Unexplained weight gain or loss
______ Unexplained fever
______ Night sweats

MALES
______ Swelling or pain in testicles
______ Sexual dysfunction

WOMEN
_____ Bleeding after menopause
_____ Vaginal discharge
_____ Sexual dysfunction
Age of first period___________ Menopause_______
Age of first live birth _________ Did you breast feed ______
Number of pregnancies_____ births_____ miscarriages_____
Prior oral contraceptives: type____________ how long _____
Hormone replacement: type______________how long______
History of breast, uterine, colon or prostate cancer in family:
____

Pt. name ____________________________________

7. PERSONAL HISTORY:

Where were you born?__________________________ How long in California? _______________________

Education _____________________________________

Any work exposure to asbestos or other toxins? ____

Do you smoke (please circle) *cigarettes* *pipe* *cigar* # years ______________ daily amount_____________

Former smokers - # years of tobacco use ___________ amount _____________ when stopped ________________

Alcohol (please circle) *Beer* *Wine* *Liquor* Amount per day ____________ week___________________

8. RELIGION:

Do you, the patient, have any religious objections to a blood transfusion: _________YES ___________No

Do you, the patient, have any other religious beliefs that would effect your medical care: _______Yes _______No

If yes, please explain: ____

____

Please indicate if there are any other concerns that you would like your doctor to know about:

____

Signature of patient ____ Date ___________________

Print name of patient____

If this has been filled out by someone other than the patient, please sign below and indicate relationship:

____
Signature of patient representative

____
Relationship of patient representative

____
Printed name of patient representative