HARRISON
HealthPartners
BREAST CARE

1780 NW Myhre Road, Suite 1220
Silverdale, WA 98383

Phone: 360-698-4500
Fax: 360-698-6960

DATE: _____

The following information is very important to your health. Please complete all pages.

Name: _____ Date of Birth: _____ Age: _____

By what name would you like to be called? _____

Reason for visit: _____

Family Doctor: _____ Oncologist: _____

Gynecologist: _____ Who referred you? _____

PERSONAL BREAST HISTORY

Have you had breast cancer in the past? Y N If yes, when: _____ Side: R L BOTH

Have you had prior breast biopsies? Y N If yes, complete the following.

Year of biopsy: _____ Side: R L BOTH Diagnosis: _____

Year of biopsy: _____ Side: R L BOTH Diagnosis: _____

Have you had a breast reduction? Y N If yes, when: _____

Do you have breast implants? Y N If yes, when: _____ Reason: _____

Date of last mammogram: _____

REPRODUCTIVE HISTORY

Age at first menses: _____ Date of last menses: _____ Are you currently pregnant: Y N

Number of pregnancies: _____ Number of live births: _____ Your age at birth of first child: _____

Have you gone into menopause? Y N If yes, have you taken hormones after menopause? Y N

What hormones have you taken? _____

Length of time postmenopausal hormones have been used: _____ How long ago? _____

Have your ovaries been removed? Y N If yes, how old were you? _____ Which ovaries? R L BOTH

FAMILY HISTORY

List any blood relative who has had breast cancer and her/his age when diagnosed: _____

_____

List any blood relative who has had ovarian cancer and her age when diagnosed: _____

_____

List any blood relative who has had colon/intestinal cancer and her/his age when diagnosed: _____

_____

Are you of Ashkenazi Jewish descent? Y N

Please check all that apply in the chart below:

	Age Deceased	Cancer	Type of Cancer/Age	Heart Attack/Age	Clotting Problems	Other Medical Conditions
Mother		☐		☐	☐	
Father		☐		☐	☐	
Sister(s)		☐		☐	☐	
Brother(s)		☐		☐	☐	
Daughter(s)		☐		☐	☐	
Son(s)		☐		☐	☐	
Mother's mother		☐		☐	☐	
Mother's father		☐		☐	☐	
Father's mother		☐		☐	☐	
Father's father		☐		☐	☐	

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Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY (Please list prior operations and dates):

_____

_____

List any non-surgical hospitalizations within the past 2 years, giving dates and reasons:

_____

_____

ANESTHETIC HISTORY

Describe any problems that you have had with anesthesia:

_____

Describe any problems that a blood relative has had with anesthesia:

_____

HEALTH MAINTENANCE:

Social History/Lifestyle

Do you / have you smoked? Y N If yes, # of packs per day?_____ # of years? _____ Year quit? _____

Do you drink alcoholic beverages? Y N If yes, how much per day? _____

Do you have a history of drug addiction? Y N If yes, what substance(s)? _____

Do you drink caffeinated beverages? Y N If yes, how many cups per day? _____

Do you exercise? Y N How often? _____

Vaccinations — Year of Last	Test/Exam — Year of Last
Tetanus/Tdap _____	Pap/Pelvic _____
Influenza (FLU) _____	Mammogram _____
Pneumonia_____	Cardiac stress _____
Hepatitis A_____	Colonoscopy _____
Hepatitis B _____	TB Test _____
HPV _____	Prostate Exam _____

Do you have a living will? Y N If yes, please provide a copy for your chart.
If no, you may want to discuss this with your family doctor.

Do you have a durable power of attorney? Y N If yes, please provide a copy for your chart.

Occupation: _____

ALLERGIES

If you are allergic to any medications, over the counter and herbal meds, and food, list the item AND the type of reaction (hives, rash, etc.):

Medicine or food:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

If you are allergic to any of the following, please circle it: TAPE IV CONTRAST DYES LATEX BETADINE SHELLFISH

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PERSONAL HEALTH HISTORY AND SYMPTOMS

Please check all that you have been treated for or are currently experiencing.

- ☐ fatigue
- ☐ weight loss
- ☐ weight gain
- ☐ fevers
- ☐ melanoma
- ☐ skin cancers
- ☐ rashes
- ☐ change in moles
- ☐ decreased hearing
- ☐ ringing in ears
- ☐ mouth sores
- ☐ dentures/caps
- ☐ hoarseness
- ☐ difficulty swallowing
- ☐ decreased vision
- ☐ blurred vision
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ asthma
- ☐ emphysema
- ☐ COPD
- ☐ shortness of breath
  - ☐ at rest
  - ☐ with activity
- ☐ tuberculosis
- ☐ chronic bronchitis
- ☐ cough
- ☐ excessive snoring
- ☐ heart attack
- ☐ angioplasty (stents)
- ☐ chest pain/angina
- ☐ irregular heartbeat
- ☐ palpitations
- ☐ atrial fibrillation
- ☐ congestive heart failure
- ☐ leg swelling
- ☐ rheumatic fever
- ☐ heart murmur
- ☐ mitral valve prolapse
- ☐ high blood pressure
- ☐ varicose veins / phlebitis
- ☐ circulation problems
- ☐ leg cramps while walking
- ☐ ulcers / gastritis
- ☐ reflux/heart burn
- ☐ nausea/vomiting
- ☐ abdominal pain
- ☐ change in bowel habits
- ☐ bloody/black stools
- ☐ colitis
- ☐ Crohn's disease
- ☐ jaundice/hepatitis
- ☐ chronic diarrhea/constipation
- ☐ blood in urine
- ☐ kidney disease
- ☐ kidney stones
- ☐ incontinence of urine
- ☐ inability to control bladder
- ☐ inability to start urine
- ☐ ovarian cyst/tumor
- ☐ endometriosis
- ☐ abnormal PAP
- ☐ sexually transmitted disease
- ☐ prostate problems
- ☐ lump or shrinkage of testicle
- ☐ joint swelling
- ☐ arthritis
- ☐ joint replacements
- ☐ metal plates or screws
- ☐ osteopenia
- ☐ osteoporosis
- ☐ chronic neck/back pain
- ☐ gout
- ☐ fibromyalgia
- ☐ muscle aches/pains
- ☐ depression
- ☐ anxiety disorder
- ☐ sleep disorder
- ☐ memory problems
- ☐ dementia/Alzheimer's
- ☐ hear voices
- ☐ loss of balance
- ☐ stroke/TIA
- ☐ seizure
- ☐ limb weakness
- ☐ numbness/tingling
- ☐ paralysis
- ☐ headaches
- ☐ dizziness
- ☐ loss of coordination
- ☐ tremors
- ☐ diabetes
- ☐ thyroid problems
- ☐ high cholesterol
- ☐ heat intolerance
- ☐ cold intolerance
- ☐ hair loss
- ☐ excessive thirst
- ☐ enlarged lymph glands
- ☐ easy/abnormal bruising
- ☐ anemia
- ☐ prior transfusions
- ☐ hemophilia
- ☐ Factor V Leiden
- ☐ vonWillebrand's disease
- ☐ ITP
- ☐ lupus
- ☐ scleroderma
- ☐ sarcoidosis
- ☐ HIV/AIDS
- ☐ rheumatoid arthritis
- ☐ seasonal allergies
- ☐ adrenal gland problems
- ☐ excessive urination
- ☐ excessive hunger
- ☐ prior cancer (list):

  _____
  _____
  _____
  _____
- ☐ no current/past problems