

Patient History Update

Patient Name: _____ DOB: _____

Allergies: _____

OFFICE USE ONLY:
Patient MRN : _____
Patient Appt Date : _____
Patient Appt Time : _____

BRIEF HISTORY:

CIRCLE ONE

1. Is there a possibility you could be pregnant? YES NO
2. If premenopausal, when was your last period? _____
3. Are you currently taking birth control? YES NO
4. If post-menopausal, are you currently taking hormone replacement therapy?
 - a. Synthetic hormone replacement YES NO
 - b. Bioidentical hormone replacement YES NO
5. Have you ever been diagnosed with breast cancer? YES NO Year? _____
 - a. Have you ever had chemotherapy YES NO
 - b. Have you ever had breast radiation? YES NO
 1. If yes, which type? Partial Whole
 - c. Have you ever taken anti-hormonal therapy? YES NO
 1. If yes, how long? _____
6. Have you ever been diagnosed with ovarian cancer? YES NO Year? _____
7. Any other health related issues since your last visit? _____

8. Please indicate below if any of the following relatives have been diagnosed with cancer. If yes, was it pre or post menopause, paternal or maternal?

CIRCLE ONE

CIRCLE ONE

CIRCLE ONE

Mother	Breast	Ovarian	Other: _____		Pre-menopause	Post-menopause
Sister	Breast	Ovarian	Other: _____		Pre-menopause	Post-menopause
Grandmother	Breast	Ovarian	Other: _____	Paternal or Maternal	Pre-menopause	Post-menopause
Aunt	Breast	Ovarian	Other: _____	Paternal or Maternal	Pre-menopause	Post-menopause
Daughter	Breast	Ovarian	Other: _____		Pre-menopause	Post-menopause
Father	Breast	Prostate	Other: _____			
Other	Breast	Ovarian	Other: _____	_____		

Please answer all of the following "yes" and "no" questions. Print information as needed on the rest of the form.

CIRCLE ONE

9. When was your last mammogram? _____
10. Was is performed at KCBC? YES NO
If not, please indicate facility _____
11. Do you have breast implants? YES NO

Patient Signature: _____

Date: _____