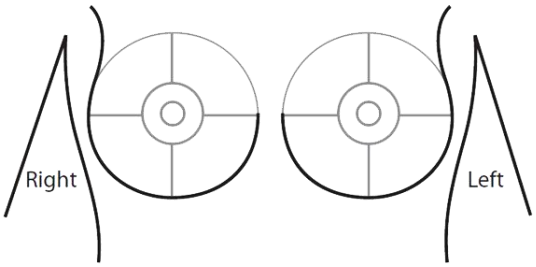
Dartmouth-Hitchcock
MANCHESTER

Department of General Surgery: Dr. Roshani Patel

- **Name:** **Date:** **DOB:**
- **Family doctor:** **Ob/Gyn:**
- **Email:** **Telephone number (best #):**
- Are you interested in signing up for *myD-H* (communicating through your electronic Dartmouth chart with your providers?)

Are there any questions that we may answer for today?

Reason for visit:
Currently, do you have any localized pain, a lump, or any other issues with your breast(s) or under your arm? If so, please mark the area in the diagram below:



Breast Health History:

Have you ever had or do you have:

Breast pain

Breast lumps

Nipple discharge

Cyst aspiration

Breast Cancer

Breast biopsy/surgery (lump removal, reduction, implant, mastopexy/mastectomy): If so list dates and facility that this was done and findings (if you know) in the table below:

Procedure	Date	Facility

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Cancer History:

Have you had any personal history of other cancers:

Have you had any prior chemotherapy or chest wall radiation?

Family history of cancer (Especially Breast, Ovarian, Colon, Melanoma, Prostate, and Pancreatic Cancer)

How many sisters do you have?
How many sisters does your mother have?
How many sisters does your father have?

How many brothers do you have?
How many brothers does your mother have?
How many brothers does your father have?

Relative:	Mother or father's side (M or F) your sibling	Cancer Type	Age of Diagnosis	Current age if alive	Age at death if passed

Has anyone in your family had genetic testing of any type?

Relative	**Mother or father's side**	**Result**	**Gene Mutation (BRCA1, BRCA 2, Li Fraumeni, Cowden's Syndrome, Familial adenomatous polyposis(FAP), Lynch,CDH1), HNPCC**

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Gynecological History

Date of last mammogram:

Bra Size:

Age of first period:

Date of last period:

Age when first child was born:

# of pregnancies:

#Miscarriages:

#Abortions:

Have you ever taken birth control pills? If so, for how long?

Age of menopause (if applicable):

Did you take hormonal replacement: No____ Yes ____ #of years _____

Have you had a hysterectomy? If so, when?

Have you had one or both of your ovaries removed? If so, when?

Have you ever taken Tamoxifen or Raloxifene?

Social History

Smoking:

Do you smoke or have you ever smoked?
If so, how many packs a day?
If you quit, when did you quit?

Alcohol:

Number of alcoholic beverages per week:

Recreational Street Drugs: If ever used or currently being used, please list type and how often you are using the drug:

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Review of Symptoms: Please review and circle any symptoms that CURRENTLY apply.

General: fevers, sweats, chills, weight loss, excessive weakness, or fatigue

Neurologic: tremors, focal neurologic symptoms, visual disturbances, headaches, fainting, blackout, paralysis, numbness or loss of sensation, tingling

Psychiatric: nervousness, tension, depression, memory problems

Eyes: blurry vision, glasses, pain, excessive tearing, spots, specks

Ears: ringing in ears, dizziness, room spinning, earache, drainage from ear, hearing aids

Nose/Sinus: nasal stuffiness, frequent colds, earache, infection, discharge

Mouth/Throat: bleeding gums, sore throat, dry mouth, sores, hoarseness

Neck: lumps, swollen glands, pain, stiffness, goiter

Cardiac: heart trouble, heart murmur, chest pain, shortness of breath, shortness of breath when lying flat

Respiratory: cough, sputum, wheezing

Endocrine: heat/cold intolerance, excessive sweating, excessive thirst or hunger, excessive urination

GI: constipation, diarrhea, indigestion, nausea, vomiting, abdominal pain, vomiting of blood

Hematology: easy bruising or bleeding

Vascular: leg pain, cramps, varicose veins, blood clots

Kidney/Genitourinary: burning with urination, blood in urine, change in frequency of urination, incontinence, hernia, sores, rash, discharge, pain

Extremities: muscle weakness, joint pain, stiffness, backache

Skin: rash, jaundice, color changes, change in hair or nails

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MEDICAL HISTORY

	Yes	No		Yes	No
Nervous System:			**Lung Disorders:**		
Seizures			Sleep Apnea		
Stroke			Severe Asthma		
Syncope			COPD		
			Bronchitis		
Vascular Disease:			Emphysema		
Carotid Stenosis			Tuberculosis		
Peripheral Vascular Disease			Pneumonia		
Bypass Procedures for Legs			Pulmonary Embolism(clot in lung)		
Blood Clot (Deep Vein Thrombosis)					
			Joint:		
Heart Disease:			Arthritis		
Coronary Artery Disease			Gout		
Heart Attack					
Congestive Heart Failure			**Vision:**		
Atrial Fibrillation			Glaucoma		
Pacemaker			Cataracts		
Mitral Valve Disease					
Aortic Valve Disease			Accidents		
Defibrillator			Burns		
High Blood Pressure					
Stent Placement			**Autoimmune Disorders:**		
Balloon Angioplasty			Lupus		
Coronary Artery Bypass(Open Heart)			Sarcoidosis		
Valve Replacement			Scleroderma		
			Sjogrens		
Diabetes			MS		
Thyroid Disease			Muscular Dystrophy		
Hepatitis A, B, or C			Liver Disease		
HIV/AIDS			Parasites		
Clotting Disorder					
Prior Blood Transfusion			**Others (List):**		
Reaction to prior blood transfusion					
Kidney Disease:					
Kidney Failure					
Urinary Infections					
Kidney Stones					

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Are you taking any blood thinning medications such as Coumadin, Plavix, aspirin, ibuprofen, naproxen or any other blood thinners that may not be listed?

Prior Surgeries:	Date: