ROPER ST. FRANCIS PHYSICIAN PARTNERS

Breast Surgery
Megan Baker, MD
Sara Kimsey, PA-C

PATIENT QUESTIONNAIRE

Name_____ Date of Birth ____/____/_____

Type of work:_____Primary Care Physician:_____

Other treating physicians:_____

Last Mammogram:_____/____/_____ Where?:_____

Medication list- please include any herbal supplements, vitamins or minerals, and over the counter medications. **(Do not complete if you have a list of your medication)**

Medication	Dose	Frequency	Medication	Dose	Frequency

Medical History-if any condition is being managed by another provider, please list the provider.

Condition	Provider

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Allergies

ALLERGY LIST	

Surgical History

Date	Surgery

Family History-please note if you family has had any of the following diseases

	Father	Mother	Sisters	Brothers	Sons	Daughters
Age, if living						
Deceased- specify age						
Hypertension						
Heart disease						
Stroke or TIAs						
Depression or mental health disorder						
Thyroid trouble						
Obesity						
Arthritis						
Suicide						
Heart attack						
Breast Cancer						
Ovarian Cancer						
Prostate Cancer						
Melanoma						
Colon or Rectal Cancer						
Other Cancer						

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Social History

Number of people in your household:_____

Marital Status: Single Married Divorced Widowed

Tobacco: Non-smoker Former Smoker Current Smoker _____ packs per day

Caffeine: None Daily Coffee, tea, cola (circle all that apply) Cups per day_____

Alcohol:

Did you have a drink containing alcohol in the past year? _____

If yes, how often did you have a drink containing alcohol in the past year?

___Never ___Monthly or less ___2-4 times a month ___2-3 times a year ___4+ more a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

___1 or 2 ___3 or 4 ___5 or 6 ___7 to 9 ___10 or more drinks

If yes, how often did you have 6 or more drinks on one occasion in the past year?

___Never ___Less than monthly ___Monthly ___Weekly ___Daily or almost daily

OBGYN

Age of onset of periods:_____

Last menstrual period:____/____/____

Age at menopause:_____

Number of pregnancies:_____ Age at first birth:_____

Number of live births:_____ Currently pregnant or breastfeeding?_____

History of breast biopsy:_____

Bra size:_____

Years on birth control:_____ Years on hormone replacement:_____

Ashkenazi Jewish?_____ History of radiation to chest?_____

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Name: _____

Date: _____

Have you experienced any of the below recently?

General: (constitutional)	**Yes**	**No**
Fatigue	O	O
Fever	O	O
Chills	O	O
Headaches	O	O
Cardiovascular:		
Chest pain	O	O
Irregular heartbeats	O	O
Swelling in legs or ankles	O	O
Gastrointestinal:		
Vomitting	O	O
Nausea	O	O
Diarrhea	O	O
Abdominal pain	O	O
Hematology/Lymph:		
Bleeding or bruising from minor injury	O	O
Anemia	O	O
Enlarged lymph nodes or gland swelling	O	O
Genitourinary:		
Frequent urination	O	O
Musculoskeletal:		
Joint pain	O	O
Back pain	O	O
Muscle tenderness	O	O

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Skin:	**Yes**	**No**
Rash	O	O
Skin lesion(s)	O	O
Skin cancer	O	O
Neurologic:		
Seizure disorder	O	O
Fainting	O	O
Dizziness	O	O
Psychiatric:		
Anxiety	O	O
Depressed mood	O	O
Panic attacks	O	O
Respiratory:		
Cough	O	O
Wheezing	O	O
Endocrine:		
Cold intolerance	O	O
Heat intolerance	O	O
Weight loss	O	O
Weight gain	O	O
Breast:		
Pain	O	O
Rash	O	O
Nipple discharge	O	O
Lump	O	O