

Carolina Breast Care Specialists, PA

First Name _____ Last Name _____ DOB _____

First Day of Last Menstrual Cycle _____ Pharmacy _____

Pharmacy Address _____ Pharmacy Phone (____) _____

Smoker? Y / N If so, how much? _____ Do you drink alcohol? Y / N If so, how much? _____

When was your last Mammogram/Breast US? _____ Where? _____

**** Current Medications:** Prescribed and over the counter.

**** Allergies:** Please also list the type of reaction that occurs.

**** Medical Care** - List any physicians that you would like sent a medical update from our office.

**** Medical History** - List any past illnesses, surgeries, or hospitalizations.

Please review and check either Yes or NO for each condition listed below.

Yes	No		Yes	No	
		Personal History of Cancer			Dizziness
		Ovarian Cysts / Tumors			Shortness of Breath
		Uterine Fibroids			Chest Pain
		Cervical Problems			Swelling of Hands, Legs or Feet
		Blood Disorders			Painful Joints
		Heart Disease			Fainting Spells
		High Blood Pressure			Jaundice
		High Cholesterol			Liver Disease
		Heart Murmur			Back Pain
		Mitral Valve Prolapse			Fatigue
		Diabetes			Loss Of Appetite
		Stroke			Weight Loss or Gain
		Pneumonia			Unexplained Fever
		Tuberculosis			Seizures
		Gallstones			Mental Disorders
		Kidney Problems			Hepatitis A, B or C
		Urinary Problems			HIV
		Headaches			Thyroid Disease
		Double Vision			Adrenal Disease

Patient Signature _____

Date _____