

## Personal History Intake Form

Last Name:  First Name:  Middle Name:  Date of Birth:

Height:  Weight:  Age:

Sex:  
 Male  Female

Marital Status:  
 Married  Single  Divorced  Widowed

Date of last physical exam:

Primary Doctor:  Phone Number:  Referring Doctor:  Phone Number:

Purpose of Consultation:

Past Medical History- Do you have or have you been treated for any of the following:

- |  |   |                                       |   |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> THYROID DISEASE     | <input type="checkbox"/> BLEEDING DISORDERS       | <input type="checkbox"/> OTHER CANCER | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> HYPERTENSION             | <input type="checkbox"/> DIABETES     | <input type="checkbox"/> SCLERODERMA          |
| <input type="checkbox"/> KIDNEY DISEASE      | <input type="checkbox"/> SEIZURES                 | <input type="checkbox"/> ASTHMA       | <input type="checkbox"/> LUNG DISEASE         |
| <input type="checkbox"/> GALLBLADDER DISEASE | <input type="checkbox"/> AIDS OR HIV              | <input type="checkbox"/> LUPUS        | <input type="checkbox"/> OTHER                |
| <input type="checkbox"/> LIVER DISEASE       | <input type="checkbox"/> GASTROINTESTINAL DISEASE | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> NONE                 |
| <input type="checkbox"/> HEPATITIS           | <input type="checkbox"/> BREAST CANCER            | <input type="checkbox"/> ARTHRITIS    |   |

For OTHER, please list or indicate:

Family History- Have blood relatives had any of the following, if yes, please list relationship:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> BLEEDING DISORDERS _____  | <input type="checkbox"/> ASTHMA _____        | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> DIABETES _____            | <input type="checkbox"/> BREAST CANCER _____ | <input type="checkbox"/> NONE _____  |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> OTHER CANCER _____  |                                      |
| <input type="checkbox"/> ARTHRITIS _____           | <input type="checkbox"/> STROKE _____        |                                      |

Pharmacy Name and Phone#:

Medication- Are you currently taking any of the following medications:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> ASPIRIN / IBUPROFEN    | <input type="checkbox"/> BIRTH CONTROL             | <input type="checkbox"/> DIURETIC (WATER PILL)       | <input type="checkbox"/> SLEEP AIDS             |
| <input type="checkbox"/> ANTIBIOTICS            | <input type="checkbox"/> BLOOD PRESSURE MEDICATION | <input type="checkbox"/> GASTROINTESTINAL MEDICATION | <input type="checkbox"/> STEROIDS               |
| <input type="checkbox"/> ARTHRITIS MEDICATION   | <input type="checkbox"/> BLOOD THINNERS            | <input type="checkbox"/> HORMONES                    | <input type="checkbox"/> THYROID MEDICATION     |
| <input type="checkbox"/> ACID REFLUX MEDICATION | <input type="checkbox"/> CHOLESTEROL MEDICATION    | <input type="checkbox"/> IRON                        | <input type="checkbox"/> WEIGHT LOSS MEDICATION |
| <input type="checkbox"/> ASTHMA MEDICATION      | <input type="checkbox"/> COUGH MEDICINE            | <input type="checkbox"/> MENTAL HEALTH MEDICATION    | <input type="checkbox"/> OTHER                  |
| <input type="checkbox"/> ANTIVIRAL MEDICATION   | <input type="checkbox"/> DIABETES MEDICATION       | <input type="checkbox"/> SEIZURE MEDICATION          | <input type="checkbox"/> NONE                   |

For OTHER, please list or indicate:

Allergies:

- Yes  No

Please list all substances/medications you are ALLERGIC to:

Do you take herbal supplements?

- Yes  No

Please List:

Use Tobacco? Vape? Marijuana?

- Yes  No



How many per day?

For how long have you smoked, vaped?

Alcohol use?

Yes

No

How much per week?

Please list and give dates of any past surgeries, illnesses or injuries. If no previous surgeries please type NONE in the spaces provided.

Surgery/Date

Surgery/Date

Surgery/Date

Surgery/Date

Surgery/Date

Surgery/Date

Women Only:

	Yes	No
Is there a chance that you may be pregnant?	<input type="radio"/>	<input type="radio"/>
Have you ever been Pregnant?	<input type="radio"/>	<input type="radio"/>
Any complications with pregnancies?	<input type="radio"/>	<input type="radio"/>
Did you breastfeed?	<input type="radio"/>	<input type="radio"/>
Have you had a mammogram?	<input type="radio"/>	<input type="radio"/>
Breast Cancer treatments?	<input type="radio"/>	<input type="radio"/>
Breast Biopsy or Mastectomy?	<input type="radio"/>	<input type="radio"/>

If you have been pregnant, how many pregnancies, and how many babies:



Please specify any complications with past pregnancies:

What was the date of your last mammogram, and the report:

If you have had Breast Cancer treatments, what type of treatment have you had, and what date did you do the treatments:

If you have had Breast Cancer treatments, which breast did you have the treatments on:

- Right Breast                       Left Breast                       Both- Right Breast and Left Breast

If you have had a Breast Biopsy or Mastectomy what date did you have them done:

If you have had a Breast Biopsy or Mastectomy which breast did you have done:

- Right Breast                       Left Breast                       Both- Right Breast and Left Breast

Oncologist Name:

Surgeon Name: