PATIENT'S PERSONAL HISTORY

Date: _____

Confidential record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

AGE: _____ HEIGHT: _____ WEIGHT: _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES TO MEDICATIONS: _____

_____

SURGICAL OPERATIONS AND DATES:

_____

_____

❑ Yes ❑ No Do you take aspirin regularly?
❑ Yes ❑ No Do you have any bleeding tendencies?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Yes	No		Yes	No	
❑	❑	Stroke	❑	❑	Rheumatic Heart
❑	❑	Tuberculosis	❑	❑	Bleeding Tendency
❑	❑	Epilepsy	❑	❑	High Blood Pressure
❑	❑	Diabetes	❑	❑	Congenital Heart
❑	❑	Hepatitis	❑	❑	Nervous Breakdown
❑	❑	Heart Attack	❑	❑	AIDS

Other: _____

❑ ❑ Do you regularly smoke? How much? _____

❑ ❑ Do you usually drink over 6 cups of coffee per day? _____

❑ ❑ Do you regularly drink alcohol or beer? How much? _____

PATIENTS CONSULTING FOR BREAST SURGERY: Date of Last Mammogram: _____

Where done? _____ Results? _____ Bra Size _____

Other Previous Breast Surgery: _____

Number of pregnancies? ____ Complications during pregnancy? ❑ Yes ❑ No

Number of live births: ____ Did you nurse? ❑ Yes ❑ No Number of children breastfed: ____

Signature _____