Comprehensive Breast Health LLC

Anna M. Knight, MD
Oncologic Breast Surgeon

PATIENT NAME: _____DOB: _____

New Patient Health History

Who is your Primary Care Physician? _____

Who is your Gynecologist? _____

Do you see any other doctors (such as for your heart, for dialysis, for your skin, pain management, or any other health condition)? If yes, please list them in the table blow, and include their information.

Physician Name	Specialty	Practice Name	Phone Number

Breast, Gynecologic, and Cancer History

Are you experiencing any of the following? Please circle all that apply.

Breast mass on your imaging Breast mass you can feel Breast cysts Breast dimpling

Breast skin color change Nipple retraction (nipple pulling inward) Breast Pain

Nipple discharge Breast itching Breast rash

If you are having a nipple discharge, what color is the discharge? _____

Which breast is having the discharge? RIGHT LEFT Both

If you are experiencing breast pain, which breast is having the pain? RIGHT LEFT Both

If you are experiencing pain, is the pain in one spot or all throughout the breast?

_____

Have you ever a breast biopsy? Yes No

Have you ever had a biopsy with the results of Atypical Ductal Hyperplasia,
Lobular Carcinoma in Situ, Atypical Lobular Hyperplasia, or Atypia? Yes No

Have you ever been diagnosed with Breast Cancer? Yes No

Have you ever had radiation to your chest? Yes No

Have you or anyone in your family had genetic testing? Yes No

Have you ever had a breast surgery? Yes No

If yes, what was the reason for your breast surgery? _____

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How old were you when you began having a menstrual cycle? _____

Have you had menopause? Yes No

If yes, how old were you at menopause? _____

Have you had your Uterus removed (hysterectomy)? Yes No

Have you had your ovaries removed? Yes No

When was your last pap smear? _____

Are you taking hormones such as estrogen, progesterone, or testosterone? Yes No

Are you taking supplements such as Black Cohosh, Soy, Boron, Fenugreek, or Red Clover? Yes No

Have you ever been pregnant? Yes No

If yes, how many children have you birthed? _____

If yes, how old were you at the time of your first live birth? _____

Did you breast feed? Yes No

If yes, how many months did you breast feed all your children (combined)? _____

What is your BRA SIZE? _____ CUP? _____

Do you have any close family members with breast cancer (grandparents? parents, uncles/aunts, siblings, children)? Yes No

If yes, please list the family member(s) and approximate age at diagnosis: _____

_____

Do you have any close family members with ovarian cancer (grandmother, mother, aunt, sister, daughter? Yes No

Do you have any close family members with pancreatic cancer (grandparents, parents, uncles/aunts, siblings, children)? Yes No

Do you have any close family members with melanoma (grandparents, parents, uncles/aunts, siblings, children)? Yes No

Do you see a Dermatologist for skin exams? Yes No

Have you ever been diagnosed with cancer other than breast cancer? Yes No

If yes, what type? _____

Are you currently pregnant? _____

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Are you currently breast feeding? _____

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Are you taking any blood thinning medications? If yes, please list the medication and your prescribing doctor here. _____

Do you take any of the following supplements? (Circle all that apply.)

Vitamin E	Chondroitin	Fish Oil	Glucosamine	Dong Quai	Ginseng	Ginger
Ephedra	Diet pills	Green Tea	Feverfew	Ginkgo Biloba	Turmeric	Garlic
Energy pills	Energy drinks					

Do you take any of the following Anti-inflammatory medications regularly?

Ibuprofen (Motrin)	Naproxen (Aleve)	Celecoxib (Celebrex)	Diclofenac (Voltaren)
Ketorolac (Toradol)	Cilostazol (Pletal)		

Past Medical History

Do you have any of the following conditions? Please circle all that apply. If you have any conditions that are not listed below. Please write the condition, where it says "other".

High Blood Pressure	High Cholesterol	Heart Attack	Diabetes
Anemia	Arthritis	Rheumatoid Arthritis	Sickle Cell
COPD	Asthma	Osteoporosis	Osteopenia
Kidney Disease	Kidney Disease Requiring Dialysis		Low Thyroid
High Thyroid	Depression/Anxiety	Bipolar/Schizophrenia	Liver Disease
Dementia	Seizure Disorder	Fibromyalgia	Migraine Headaches
Atrial Fibrillation	Heart Failure	Stroke	Pulmonary Embolism/DVT
Lupus	Colon Polyps	Obstructive Sleep Apnea	

Other: _____

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Past Surgical History/Past Procedure History (Please circle all that apply)

Have you ever had a surgery or procedure? If yes, please circle all that apply. If you do not see the procedure you have had, please write it below where it says, "other".

Cardiac Catheter	Pacemaker/AICD	Colonoscopy	EGD
Appendectomy	Gallbladder Surgery	Colon/Intestinal Surgery	Gastric Bypass
Stomach Surgery	Tummy Tuck	Breast Implants	Breast Reduction
Amputation	Fistula for Dialysis	Hip surgery	Knee Surgery
Shoulder Surgery	Other: _____		

If you have had a Colonoscopy, when was your last colonoscopy? _____

Do you have any implanted devices? (Hip, knee, implants, pacemaker, etc.) Yes No

If yes, what do you have? _____

Allergies

Do you have any allergies to medications? Yes No

If yes, please list the medication, and your reaction to the medication (such as rash, throat swelling, etc.).

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to the following? (Circle all that apply)

Latex Adhesive Betadine Chlorhexidine Steri-strips Dermabond

If you are allergic to adhesive, is there a type of tape that you can tolerate? Yes No

If yes, what is it? _____

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Family History

In regard to your family history below, please indicate the family member with the condition. Please list any parent, grandparent, aunt/uncle, sibling, or children with the following:

Do any close relatives have a history of any other type of cancer? Yes No

If yes, who, and approximately how old were they at the time of diagnosis? _____

_____

Do any close relatives have Diabetes? Yes No

If yes, who? _____

Do any close relatives have Heart Problems? Yes No

If yes, who? _____

Do any close relatives have Kidney Problems? Yes No

If yes, who? _____

Do any close relatives have Dementia? Yes No

If yes, who? _____

Has anyone in your family had a Stroke? Yes No

If yes, who? _____

Are there other conditions that run in your family? Yes No

If yes, what is it, and who has these conditions? _____

_____

Vaccines (Please list date last given):

COVID-19: _____ Influenza: _____

Pneumococcal (Pneumonia): _____ Shingles: _____

Social History

Do you drink alcohol? Yes No

If yes, how often? 1-3x/month 1-2x/week 3-5x/week daily

How many alcoholic drinks do you drink at a time? 1-2 3-4 5 or more

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Do you use tobacco? Yes No

If yes, what form? Cigarettes Cigars Chewing Tobacco Pipe

If yes, how much do you use per day? _____

If yes, how long have you used tobacco? _____

Do you vape? Yes No

Do you use any other substances such as: Marijuana Cocaine Heroin Other _____

Do you feel safe at home? Yes No

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Review of Systems: Are you experiencing any of the following? (Check all that apply.)

General	☐ Decreased Energy Level ☐ Lack of Appetite ☐ Fever ☐ Chills ☐ Weight Gain ☐ Weight Loss	Genitourinary	☐ Blood In Urine ☐ Frequent Urinary Tract Infections ☐ Pain with Urination
Eye	☐ Blurred Vision ☐ Double Vision ☐ Dry Eyes ☐ Watery Eyes ☐ Itchy Eyes	Musculoskeletal	☐ Muscle Cramps ☐ Joint Stiffness or inflammation ☐ Joint Pain
ENT	☐ Hearing Loss ☐ Ringing in Ears ☐ Dizziness ☐ Nosebleeds ☐ Nasal/Sinus Blockage	Psychiatric	☐ Changes in Mood ☐ Changes in Behavior ☐ Changes in Coping ☐ Changes in Coping ☐ Changes in Sleep Habits ☐ Changes in Personality
Gastrointestinal	☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn	Endocrine	☐ Excessive Thirst or hunger ☐ Excessive Urination ☐ Heat or cold intolerance
Neurological	☐ Difficulty with Balance ☐ Difficulty walking ☐ Tremors ☐ Seizures ☐ Difficulty with Concentration ☐ Numbness/Tingling	Hematologic/Lymphatic	☐ Easy bruising or bleeding ☐ Difficult to stop bleeding once starts
Respiratory	☐ Cough ☐ Shortness of Breath ☐ Trouble catching breath ☐ Snoring ☐ Wheezing	Skin	☐ Rash ☐ Changes in Skin Coloration ☐ New Growths on Skin ☐ Skin Breakdown/wounds
Cardiac	☐ Palpitations ☐ Irregular heartbeat ☐ Swelling in hands and feet		

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Medication List

(Please provide a printed medication list or complete the following for all prescription and over the counter medications)

Medication Name	Purpose	Dosage	Frequency