OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

OHC BREAST SURGICAL ONCOLOGY
FEMALE NEW PATIENT INTAKE FORM

First name: ___________________________________ Last name: ___________________________________

Today's date: __________________ DOB: ____/____/____ Age: ______ SS: (Last 4 digits): ____________________

Reason for visit: ____

Referring doctor: ___________________________________ Primary care doctor: _______________________

Are you planning to bring anyone to your visits, if so, name/relationship:

____

Have you ever had any breast problems? ❍ Yes ❍ No

If yes, please describe (cancer, pain, nipple discharge, abscess, cysts, other): ______________________________

Have you ever had a breast biopsy? ❍ Yes ❍ No Year ______ Where? _________________________________

If yes, results: ❍ Normal/Benign ❍ Hyperplasia (not atypia) ❍ Atypical hyperplasia

❍ Lobular Carcinoma in Situ (LCIS) ❍ Unknown ❍ Other ____

Have you had any breast surgery? ❍ Yes ❍ No If yes, Year: ______ Type of surgery: ________________________

Reason: ___________________________________ Where: ______________________________________

Have you ever had radiation treatment to your chest area and/or to a breast? ❍ Yes ❍ No

Bra size: ____________ Height: __________ Weight: _____________

Medical History – Please check all that apply or have applied in the past

❍ Headaches
❍ Stroke
❍ Thyroid problem
❍ Diabetes (Type I or II)
❍ Atrial fibrillation
❍ Congestive heart failure
❍ Heart disease/Heart attack
❍ High blood pressure
❍ High cholesterol
❍ Asthma
❍ COPD/Emphysema
❍ Sleep apnea
❍ Bleeding disorders/Anemia
❍ Kidney problems
❍ Liver problems
❍ Hepatitis
❍ HIV/AIDS
❍ Alcoholism
❍ Arthritis/Gout
❍ Epilepsy/Seizures
❍ Testicular mass/Tumor
❍ Lupus/SLE
❍ Collagen vascular disease
❍ Scleroderma
❍ Cancer (type: _______)

Please list any additional medical problems and/or surgeries you have had:

____

____

Please list any allergies:

____

Do you currently take any of the following? ❍ Yes ❍ No (Mark all that apply)

❍ Aspirin ❍ Coumadin/Warfarin ❍ Eliquis ❍ Xarelto ❍ Plavix ❍ Other

Patient name: ____ DOB: ____/____/____ Age: _______ SS: (Last 4 digits): __________

OB/GYN History:

Age at first menstrual cycle _______ Last menstrual cycle (if applicable) _____________

pregnancies ______ # births _______ Age at first live birth ________

Did you breast feed your child(ren)? ❍ Yes ❍ No ❍ N/A

Have you gone through menopause? ❍ Yes ❍ No Age: ________

Have you had a hysterectomy? ❍ Yes ❍ No Age: ________ Reason: ________________________________

Have you had your ovaries removed? ❍ Yes ❍ No Age when ovaries were removed: __________ ❍ Unknown

Have you ever taken birth control pills? ❍ Yes ❍ No # of years _____ Still using? ❍ Yes ❍ No

Have you ever taken hormone therapy? ❍ Yes ❍ No, Still using? ❍ Yes ❍ No Stopped ___ years ago

If yes, medication: _______________________ # of years taken ____________

Family History:

Have you ever had any genetic testing? ❍ Yes ❍ No Year _______ Results ______________________________

Have any family members had testing? ❍ Yes ❍ No Who and results ___________________________________

Are you of Ashkenazi Jewish descent: ❍ Yes ❍ No Mother or father's side? __________________________

Please list anyone in your family who has had cancer:

Family member with cancer (ex. parents, siblings, paternal/maternal grandparents, aunts, uncles, and cousins)	Type of cancer	Age at diagnosis	Alive, current age	If deceased, age at death

How many of the following relatives do you have?

Maternal aunts ____ Paternal aunts _____ Daughters______ Sisters _____ Half sisters (maternal/paternal) ______

Social History:

Alcohol use: ❍ Never ❍ Socially ❍ Daily # Drinks per day _____

Tobacco use: ❍ Yes ❍ No, ❍ Former smoker Quit date __________

If yes, # cigarettes/day _____________ # years _________________

Occupation: ____

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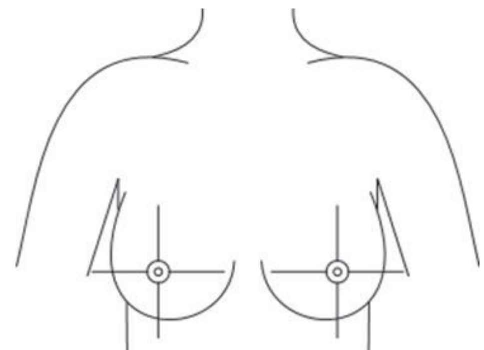

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