BaylorScott&White
BREAST CARE SPECIALISTS OF TEXAS
FORT WORTH
A member of HealthTexas Provider Network

Name: ________________________

Date of Birth: __________________

Today's Date: __________________

Health History Form – New Patient

Thank you for choosing our clinic for your healthcare needs. We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information to be kept in your electronic medical record.

Who referred you to BSW Breast Care Specialists of Texas? ______________________________________

What is the reason for your visit?

____
____

Please list all physicians you are seeing by name and specialty:

____
____

Allergies

Please list all allergies you have (including latex, dyes, etc.) and indicate the type of reaction.

____
____
____

Medications

Please list your current medications and dosages (include herbal medications, dietary supplements, vitamins, Tylenol, Ibuprofen, injectables/infusions and other over-the-counter medications)

Medication name	Dose and Frequency

Pharmacy

Preferred Local Pharmacy: ______________________________ Phone: ____________________

Address: ____

Breast History

Do you perform self-breast Exams? YES NO

Do you get an annual mammogram? YES NO Date of last mammogram: ___________

Have you had a breast biopsy or procedure in the past? YES NO

Are you currently being, or have you ever been, treated for breast cancer? YES NO

Bra size: ____________

Gynecological History (female patients only)

Age of first period: _________

Age of menopause: _________

Number of pregnancies: _____ Number of live births: _____ Your age at first live birth: _____

Did you breast feed? YES NO If yes, for how long? ___________________________________

Are you currently on birth control? YES NO

Are you currently taking, or have you taken in the past, hormone replacement therapy? YES NO

If yes, how long were you taking it? ____

Social History

Do you smoke? ☐Yes ☐No ☐Former

Do you use chewing tobacco? ☐Yes ☐No ☐Former

Do you drink alcohol? ☐Daily ☐Socially ☐Never ☐Former

Do you use recreational/street drugs? ☐Daily ☐Socially ☐Never ☐Former

Type: ___________________________________

Medical History / Review of Systems

Please check all that apply.

☐Alzheimer's disease	☐Angina	☐Asthma
☐Anemia	☐Anxiety	☐Blood Clots (DVT/PE)
☐Anesthesia Complications	☐Arthritis	☐Cancer

☐Heart Failure
☐Clotting Disorder
☐COPD
☐Coronary Artery Disease
☐Crohn's Disease
☐Depression
☐Diabetes Mellitus
☐Emphysema
☐GERD
☐Heart Failure
☐Heart Murmur
☐Kidney Disease
☐Myocardial Infarction
☐Obesity
☐Osteoporosis
☐Osteopenia
☐Other Skin Cancer
☐Psychiatric Issues
☐Pancreatitis
☐Seizures
☐Sickle Cell Anemia
☐Sleep Apnea
☐Stroke
☐TB
☐Thyroid Disease
☐Ulcerative Colitis
☐Any metal in body
☐Activity change

☐Appetite change
☐Chills/Sweating
☐Fatigue
☐Immunocompromised
☐Adenopathy
☐Bruises/Bleed easily
☐Agitation
☐Behavioral problems
☐Confusion
☐Decreased concentration
☐Hallucinations
☐Self-Injury
☐Sleep disturbance
☐Suicidal thoughts
☐Congestion
☐Dental problems
☐Hearing loss
☐Mouth sores
☐Nose bleeds
☐Sore throat
☐Trouble swallowing
☐Voice change
☐Heart Valve Disease
☐Hepatitis/Liver Disease
☐HIV/AIDS
☐Radiation Treatment
☐Hyperlipidemia
☐Hypertension

☐IBD
☐Fever
☐Weight change
☐Excessive thirst
☐Excessive urination
☐Dizziness
☐Facial asymmetry
☐Headaches
☐Seizures
☐Speech difficulty
☐Chest Pain
☐Leg Swelling
☐Palpitations
☐Hair change
☐Wound healing issues
☐Joint pain
☐Back pain
☐Gait problems
☐Joint swelling
☐Muscle pain
☐Neck pain/stiffness
☐Breast mass
☐Skin changes
☐Nipple discharge
☐Abdominal pain
☐Blood in stool
☐Constipation
☐Diarrhea

☐Nausea ☐Vomiting ☐Rash

Other: ____

Please list any surgeries with dates:

____

____

____

Family History

☐No knowledge of family history ☐Adopted

Please list family medical history below, be sure to include any breast issues.

	Medical Problems	Deceased	If deceased, cause of death
Mother			
Father			
Sibling			
Sibling			
Sibling			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			