Breast Care Center, A *branch* of Cedar Valley Medical Specialists, P.C.
1753 West Ridgeway Ave., Suite 104, Waterloo, IA 50701

Medical History Questionnaire

We need to know your past medical history to best understand how we can help you. All information is confidential and will not be released to anyone, unless authorized by you in writing.

1. What is your full name?______________________________ Date:________________
2. Why are you here today?________________________ Who referred you?________________
3. Do you take any medications? ____No ____Yes ⇒ Please list:______________________________

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4. Do you take blood thinners or any aspirin products? ____No ____Yes ⇒ Please list:____________________
5. **Drug Allergies?** ____No ____Yes ⇒ Please list and **include the reaction** (rash, hives, stomach upset, etc):

____

____

Latex Allergy? ____No ____ Yes ⇒ Reaction:____________________________________

6. Previous Operations? ____No ____Yes ⇒ Please list:________________________________

____

7. Previous Hospitalizations? ____No ____Yes ⇒ for what?________________________________

____

8. Please circle illness or conditions that ***you have had***: Diabetes Cancer Stroke Heart Trouble High Blood Pressure

Hepatitis Gout Kidney Disease Bleeding Tendencies Blood Clots Tuberculosis Asthma Pneumonia

Broken Bones Other:____

9. Do you smoke? ____No ____Yes ⇒ Amount:______________________________

   Did you ever smoke? ____ No ____ Yes ⇒ When did you quit?______________________
10. Do you drink alcohol? ____No ____Yes ⇒ Amount:____________________________
11. Have you ever had a blood or blood product transfusion? ____No ____Yes ⇒ Year:______________
12. Have you ever had an unusual reaction to any general or local anesthetic? ____No ____Yes ⏎

    Please explain:____
13. Have you been tested for HIV (AIDS) ____No ____Yes

    Have you ever used intravenous drugs (street drugs)? ____No ____Yes
14. Is there any other information about your health, which the doctor should know?____________________

____

REVIEW OF SYSTEMS: Signs and/or symptoms you may be experiencing or have experienced within the last 3 months.

YES	NO		YES	NO		YES	NO	
___	___	Weight Gain	___	___	Shortness of breath	___	___	Back pain
___	___	Weight Loss	___	___	Difficulty breathing	___	___	Hearing loss
___	___	Fever	___	___	Anemia/blood disease	___	___	Double vision
___	___	Chills	___	___	Blood clots	___	___	Blurred vision
___	___	Difficulty swallowing	___	___	AIDS	___	___	Memory loss
___	___	Ulcers	___	___	Breast lumps/pain	___	___	Anxiety
___	___	Constipation	___	___	Bladder infections	___	___	Other:___________
___	___	Diarrhea	___	___	Migraines			___________
___	___	Bowel Disease	___	___	Neck pain			

FAMILY HISTORY (Immediate family – parents, brothers, sisters and your children if applicable.)

	Father	Mother	Brother	Sister	Son	Daughter	NOTES
Diabetes							
Cancer – and type							
Stroke							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Bleeding Tendencies							
Blood Clots							
Tuberculosis							
OTHER:							

Patient Signature: ______________________________ Date ________________

Subsequent Review:

Patient Review: ___ changes above ___ no changes Patient Sign:______________________ Date:________

Patient Review: ___changes above ___ no changes Patient Sign:______________________ Date:________

Patient Review:___changes above ___ no changes Patient Sign:______________________ Date:________

Reviewed by Physician______________________________ Date ________________

Patient Name:______________________________ Date of Birth:________________