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?_____ Birth Date:_____
2. Why are you here today?_____ Who referred you?_____
3. Do you take any medications? ____No ____Yes ➡ Please list:_____

_____

_____

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?_____

_____

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