CEDAR VALLEY
Breast Care Center
A branch of CVMS

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

Medical Health History

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 any illness or condition that ***you have had***: Diabetes Stroke Heart Disease High Blood Pressure

   Hepatitis Kidney Disease Bleeding Tendencies Blood Clots Tuberculosis Asthma Pneumonia

   Cancer (and type:) ___________________________ Other:____

9. Do you smoke? ____No ____Yes ➡ Amount/day:____

   Did you ever smoke? ____ No ____ Yes ➡ How long/when did you quit?___________________________________

10. Do you drink alcohol? ____No ____Yes ➡ Amount/week:____

11. Have you ever had a blood or blood product transfusion? ____No ____Yes ➡ Reason/Year:_______________________

12. Have you ever had an unusual reaction to any general or local anesthetic? ____No ____Yes

    If yes, please explain:____

13. Have you been tested for HIV (AIDS) ____No ____Yes

14. Have you ever used intravenous drugs (street drugs)? ____No ____Yes

15. Is there any other information about your health, which the doctor should know?_______________________________

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