FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Breast Surgery Health History Questionnaire

Name _____

Date of Birth ____/____/____

Who is your primary care provider? _____

Who referred you our office ? _____

Please Indicate Your Current Breast Symptoms		
Symptom	**Location**	
Mass or lump	☐ Left breast	☐ Right breast
Nipple discharge	☐ Left breast	☐ Right breast
Skin changes	☐ Left breast	☐ Right breast
Underarm swelling	☐ Left breast	☐ Right breast
Underarm lump	☐ Left breast	☐ Right breast
Underarm pain	☐ Left breast	☐ Right breast
Breast pain	☐ Left breast	☐ Right breast
Abnormal ultrasound	☐ Left breast	☐ Right breast

Breast History					
Age you started menstruating:			Stopped menstruating:		
Have you ever been pregnant? ☐ Yes ☐ No					
If yes, how many times?			How many children were born?		
How old were you when your first child was born?					
Did you breast feed ? ☐ Yes ☐ No					
Have you had a hysterectomy? ☐ Yes ☐ No			If yes, were your ovaries removed? ☐ Yes ☐ No		
Have you ever received chest radiation as a treatment? ☐ Yes ☐ No			If yes, why?		
Have you ever had a breast biopsy? ☐ Yes ☐ No			If yes, which side? ☐ Left ☐ Right		
If yes, what kind of biopsy was performed?					
What did the biopsy results show?					
Have you had exposure to DES? ☐ Yes ☐ No					
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No					
Have you had genetic testing in the past ? ☐ Yes ☐ No					
Have you ever used the following?		**If yes, what type ?**		**At what age?**	
Hormonal birth control ☐ Yes ☐ No					
Fertility medications ☐ Yes ☐ No					
Hormone replacement ☐ Yes ☐ No					
Any other kinds of hormones ☐ Yes ☐ No					
Does anyone in your family have history of ?		**Relationship to you**		**At what age?**	
Breast Cancer ☐ Yes ☐ No					
Ovarian Cancer ☐ Yes ☐ No					
Other Cancer ☐ Yes ☐ No					

Health History
Do you have a history of the following? ☐ DVT ☐ Pulmonary embolism ☐ Heart attack ☐ Stroke ☐ Not applicable

Please if you are experiencing any of the following:			
☐ None apply	☐ Blurred vision	☐ Vomiting	☐ Seasonal allergies
☐ Fever	☐ Double vision	☐ Abdominal pain	☐ Excessive thirst
☐ Chills	☐ Light sensitivity	☐ Diarrhea	☐ Swollen lymph nodes
☐ Unexplained weight loss	☐ Eye pain	☐ Constipation	☐ Dizziness
☐ Fatigue	☐ Eye discharge	☐ Blood in stool	☐ Tingling in arms or legs
☐ Sweating	☐ Chest pain	☐ Dark tary stool	☐ Tremors
☐ Weakness	☐ Palpitations	☐ Painful urination	☐ Sensory changes
☐ Rash	☐ Shortness of breath when lying down	☐ Urinary urgency	☐ Speech changes
☐ Itching	☐ Leg cramping	☐ Urinary frequency	☐ Weakness to one body area
☐ Headaches	☐ Leg swelling	☐ Blood in urine	☐ Seizures
☐ Hearing Loss	☐ Shortness of breath during sleep	☐ Flank pain	☐ Loss of consciousness
☐ Ringing in ears	☐ Cough	☐ Muscle pain	☐ Depression
☐ Ear pain	☐ Coughing up blood	☐ Neck pain	☐ Suicidal ideas
☐ Ear discharge	☐ Sputum production	☐ Back pain	☐ Substance abuse
☐ Nosebleeds	☐ Shortness of breath at rest	☐ Joint pain	☐ Hallucinations
☐ Congestion	☐ Wheezing	☐ Unexplained falls	☐ Anxiety
☐ Wheezing	☐ Hearthburn	☐ Joint swelling	☐ Insomnia
☐ Sore throat	☐ Nausea	☐ Easy bleeding/bruising	☐ Memory loss

Patient Signature : _____ Date: _____