Arch Health Partners

Jean McLaughlin WOMEN'S CENTER FOR HEALTH AND HEALING

Date: _____

Name _____ Sex: ☐ Female ☐ Male
Last First Middle

Date of Birth: _____ Age: _____ Social Security # _____- _____- _____

Home Address_____

e-Mail Address_____

Home Phone (___)_____ Cell Phone (___)_____

Business Phone (_ ___)_____ The preferred phone is ☐ H ☐ C ☐ B

Emergency contact: _____ Relationship _____

Address _____ Phone: (_____)_____

PCP:
1). Name: _____ Phone: (_____)_____

Address: _____

Referring Physician:
2). Name: _____ Phone: (_____)_____

Address: _____

Periodic reports may be sent to your Physicians. To which of the above would you like these reports sent?
1). _____ 2). _____ 3). _____

We would like to know how you selected this practice:

☐ My Physician recommended I come
☐ I asked my physician to refer me
☐ I referred myself
☐ A friend or relative referred me
☐Other: _____

REASON FOR SEEKING CARE

1. **Check one.** ☐ **Right** ☐ **Left** ☐ **Bilateral**

☐ Breast Cancer
☐ Abnormal mammogram
☐ Lump in breast found by self
☐ Lump in breast found by clinician
☐ Lump in breast, don't recall who found it
☐ Armpit or axillary mass
☐ Bloody discharge from nipple
☐ Inverted nipple
☐ Breast pain or discomfort
☐ Other _____

[ ] At approximately what date did this symptom (including abnormal mammogram) become apparent to you?

2. Were there any other problems? Choose all that apply.

☐ Breast Cancer
☐ Abnormal mammogram
☐ Lump in breast found by self
☐ Lump in breast found by clinician
☐ Lump in breast, don't recall who found it
☐ Armpit or axillary mass
☐ Bloody discharge from nipple
☐ Inverted nipple
☐ Breast pain or discomfort
☐ Other _____

SMOKING AND ALCOHOL HISTORY

3. Have you ever smoked?
☐ Yes; but only in the past
☐ Yes; currently_____packs per day, since_____
☐No;

4. Have you ever or do you currently drink alcohol?
☐ Yes; but only in the past
☐ Yes; currently_____drinks per week, since_____
☐No;

GYNECOLOGIC HISTORY

5. At what age did you have your first period?
☐ Younger than 11
☐ 11
☐ 12
☐ 13
☐ 14
☐ 15
☐ 16
☐ Older than 16

6. How many times have you been pregnant? [ ]

7. How many live births have you had? [ ]

8. a. If you have children, what was your age at your first time full term pregnancy? [ ]

8. b. If you have children, what was your age when you had your last full term pregnancy? [ ]

9. Have you had a menstrual period within the last six months?
☐ No (skip to question 11)
☐ Yes, natural menstrual periods or menstrual periods on birth control pills
☐ Yes, have menstrual periods on hormone replacement therapy
☐ Unknown

10. When was your last menstrual period? _____/_____/_____

11. If you have NOT had a menstrual period within 6 months, why did your periods stop?

- ☐ Pregnancy and/or breast feeding
- ☐ Natural menopause
- ☐ Hysterectomy with ovaries left in
- ☐ Hysterectomy with both ovaries removed
- ☐ Hysterectomy, unsure about ovaries
- ☐ Both ovaries removed, no hysterectomy
- ☐ Chemotherapy or radiation therapy
- ☐ Other_____

12. If you have not had a period within the last 6 months, at what age did you stop having periods? Or, if both ovaries have been removed, how old were you when they were removed? ☐

13. If both ovaries have been removed, what was the date of surgery (month/year)? ☐

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14. Have you ever used, or do you use, estrogen or estrogen replacement therapy? Do NOT include birth control pills.

- ☐ No, never (skip to question 17)
- ☐ Yes, currently
- ☐ Yes, in the past

15. If you used estrogen currently or in the past, what form of estrogen do/did you use? Check ALL that apply.

- ☐ A pill
- ☐ A patch
- ☐ Vaginal cream
- ☐ Other

16. How many total years have you used estrogen replacement? ☐ Year(s)

17. a. Do you use, or have you ever used, birth control pills?

- ☐ No, never (skip to question 18)
- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ Not sure

b. If so, for how many years? ☐ Years

18. Have you ever used fertility drugs?

☐ Yes ☐ No (If no, skip to question 19)

a. If yes, have you used Clomiphene citrate (i.e. Serophene, Clomid)?
☐ Yes ☐ No ☐ Don't know

b. If yes, have you used an injectable hormone (i.e. hMG, Gonal-F, Follitism)?
☐ Yes ☐ No ☐ Don't know

19. a. Have you ever breast fed?

☐ Yes ☐ No (If No, skip to question 20)

b. If yes, how many months (in total) have you breastfed? ☐ Months

c. If yes, how many years (or months) ago did you last breastfeed? ☐ Months or years (please circle)

d. What is your bra - cup size ☐

20. What was the approximate date of your last pelvic exam (internal female exam)? ☐

MEDICAL HISTORY

21. Do you now have, or have you ever had any of the following? Please provide details.

A heart attack?	☐ Yes ☐ No ☐ Don't know
Heart disease?	☐ Yes ☐ No ☐ Don't know
Lung disease?	☐ Yes ☐ No ☐ Don't know
High blood pressure?	☐ Yes ☐ No ☐ Don't know
A stroke, blood clot/bleeding in the brain, TIA?	☐ Yes ☐ No ☐ Don't know
Diabetes or high blood sugar?	☐ Yes ☐ No ☐ Don't know
Problems with your kidneys?	☐ Yes ☐ No ☐ Don't know
Alzheimer's Disease, or another form of dementia?	☐ Yes ☐ No ☐ Don't know
Hepatitis, Cirrhosis, or serious liver damage?	☐ Yes ☐ No ☐ Don't know
AIDS / HIV?	☐ Yes ☐ No ☐ Don't know
Leukemia or polycythemia vera?	☐ Yes ☐ No ☐ Don't know
Lymphoma?	☐ Yes ☐ No ☐ Don't know
Cancer (**other than breast cancer**)?	☐ Yes ☐ No ☐ Don't know
Tuberculosis?	☐ Yes ☐ No ☐ Don't know
Bleeding tendency or easy bleeding?	☐ Yes ☐ No ☐ Don't know
Skin Disease?	☐ Yes ☐ No ☐ Don't know
Lumps in breast?	☐ Yes ☐ No ☐ Don't know
Pain in breast?	☐ Yes ☐ No ☐ Don't know
Nipple discharge?	☐ Yes ☐ No ☐ Don't know
Lump in the arm pit?	☐ Yes ☐ No ☐ Don't know
Recent gain or loss of weight?	☐ No Wt. Gain:_____ Wt. Lost: _____
Other medical conditions not mentioned above and details	

PAST SURGERY/OPERATIONS

22. PLEASE LIST IN CHRONOLOGICAL ORDER:

MONTH	YEAR	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

MEDICATIONS

23. Please list any medications you are now taking:

	Name of Medication	Dosage	Frequency
Hormones or Birth Control Pills:			
Antidepressent/Antianxiety Pills			
Tranquilizers/Sleeping Pills			
Pain Pills			
Other			

24. Please list or describe any other therapies, vitamins or herbal remedies you are taking currently, why & how you take each (such as frequency and amount). If you need more space, continue on back.

Name of vitamin, herb or therapy: Purpose: Dosage & Frequency Start date:

_____

_____

ALLERGIES

25. Are you allergic to any medicines? ☐ Yes ☐ No
*If so, please list any medications to which you have had an allergic reaction, and the type of reaction:

26. Are you allergic to any foods? ☐ Yes ☐ No
*If so, please list any foods to which you have had an allergic reaction, and the type of reaction:

FAMILY HISTORY

Please include only blood relatives, both living and deceased.

27. How many sisters do you have? ☐

28. How many brothers? ☐

29. How many daughters? ☐

30. How many sons? ☐

31. Do you have any blood related family relatives who have been diagnosed with cancer? If yes, please use the chart below to indicate their relationship to you, the type of cancer they have, their age at diagnosis, and whether or not they are still living. Please print the type of relative in the Relative column and the type of cancer in the Cancer Type column*

NOTE: If you have more than one relative of a particular type who has been diagnosed with cancer, please assign each a number in the Relative column (e.g. sister 1 and sister 2)

Blood Relative (**see list below)	Maternal or Paternal?	Cancer type (**see list below)	Age at Diagnosis	Is Age Estimated to the Decade?	Alive?
SAMPLE*: Mother	M	Breast Cancer	63	☐ Yes	☒ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown
				☐ Yes	☐ Yes ☐ No ☐ Unknown

* For example, if your mother was diagnosed with breast cancer at age 63 and she is still living, you would print Mother in the Relative column, Breast Cancer in the Cancer Type column, 63 in the Age at Diagnosis column, and check off Yes in the alive column. If you only knew that she was diagnosed sometime in her 60's, you would print 60 in the Age at Diagnosis column and check off the Yes box in the Is Age Estimated to the Decade column.

32. Were any of your grandparents of Ashkenazi Jewish descent?

☐ Yes ☐ No ☐ Don't know

33. Have you been tested for the BRCA gene mutation?

☐ Yes ☐ No ☐ Don't know

34. If Yes what was the result:_____

PHYSICAL ACTIVITY

35. Which option below best describes your level of physical activity OVER THE PAST WEEK? Choose one.

- ☐ Fully active, able to carry on all usual activities without restriction
- ☐ Restricted in strenuous activity; can walk; able to carry out light housework
- ☐ Can walk and take care of self; up more than ½ day
- ☐ Need some help in taking care of self, spend more than ½ day in bed or chair
- ☐ Cannot take care of self at all and spend all my time in bed/chair