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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I prefer to be called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I currently have (circle): ◊No breast problems ◊Breast pain ◊Breast lump or mass ◊Nipple discharge ◊Breast skin changes

◊Abnormal Mammogram ◊Abnormal breast MRI ◊Family history of breast cancer ◊Breast cancer

◊Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have had a previous:

Breast biopsy (circle): yes no If yes, list year(s) and results, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cyst aspiration (circle): yes no If yes, list year(s), if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast infection (mastitis) or abscess (circle): yes no

Breast reduction: yes no Breast implants: yes no other breast surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gynecologic History:

Age with first period: \_\_\_\_\_\_\_\_ First day of most recent menstrual period (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_\_\_\_\_ Number of live births: \_\_\_\_\_\_\_ Age with first live birth: \_\_\_\_\_\_\_\_\_\_\_

Breast fed: yes no Duration with each child: \_\_\_\_\_\_\_\_\_\_\_ Age with Menopause (if applicable):\_\_\_\_\_\_\_\_

Hormone use (circle): birth control pills hormone replacement therapy after menopause fertility medication

Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of years of use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you exposed to DES (diethylstilbestrol) in utero? yes no Have you ever taken DES? yes no

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Bra size: \_\_\_\_\_\_\_\_\_\_\_\_\_

I have the following medical problems (circle):

Hypertension Heart Disease Heart murmur Stroke Irregular Heartbeat Diabetes High Cholesterol

Thyroid Disease Asthma COPD Sinus problems GERD (reflux) Peptic ulcers Crohn’s Disease

Chronic Ulcerative Colitis Celiac Disease Osteoporosis Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type)

Arthritis Venous thrombosis (blood clot) Pulmonary embolism Coagulopathy (clotting disorder)

Bleeding Diathesis (bleeding tendency) Seizures Depression Other psychiatric diagnosis

Kidney failure/insufficiency Cataracts Glaucoma Hearing loss Psoriasis Uterine Fibroids

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgery you have had and the year(s) it was performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative or Complementary medical therapy or herbal remedies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take aspirin on a daily basis? yes no

Medication allergies: ◊ I have no medication allergies.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental allergies: ◊ I have no environmental allergies.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to Latex? yes no

Cigarette Smoking: \_\_\_\_\_\_\_\_ packs per day for \_\_\_\_\_\_\_\_\_ years. Quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Alcohol use: \_\_\_\_\_\_\_\_\_\_ drinks per day Exercise frequency: \_\_\_\_\_\_\_\_\_\_\_ times per week

Caffeine: \_\_\_\_\_\_\_\_\_\_\_\_ (coffee, tea, cola, chocolate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (amount) per day

Diet: High Medium Low Fat (circle one)

Have you had a colonoscopy? yes no If yes, list year of last one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last gynecologic examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had your Vitamin D level checked? yes no If yes, list year of last study\_\_\_\_\_\_\_\_\_\_\_\_\_ and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a DEXA scan (bone density study)? yes no If yes, list year of last study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I currently have the following symptoms (please circle): ◊ I have none of the physical symptoms listed below.

fever chills fatigue weight loss \_\_\_\_\_\_\_\_ ( amount) weight gain \_\_\_\_\_\_\_\_ (amount) obesity

chest pain palpitations cough shortness of breath: at rest with activity sinus pain seasonal

allergies/ hay fever abdominal pain loss of appetite nausea vomiting constipation diarrhea

bloody stool abdominal bloating pain with urination incontinence frequent urination

vaginal spotting vaginal discharge vaginal dryness hot flashes bone pain joint pain back pain

leg swelling weakness of an arm or leg dizziness numbness/ tingling headaches ringing in ears

bloody nose mouth ulcers dental problems blurred vision impaired vision neck pain skin rashes

clotting tendency bleeding tendency other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history of cancer:**

The presence of an abnormal gene (BRCA 1 or 2) which strongly increases one’s risk for breast cancer is found more commonly in people of certain ethnic backgrounds.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Relative** | **Breast cancer/Age when diagnosed** | | **Ovarian Cancer/Age** | **Uterine Cancer/ Age** | **Colon Cancer/ Age** | **Prostate Cancer/ Age** | **Other Cancer/ Age** |
|  | **One breast** | **Both breasts** |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |
| Daughter |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |
| Mat. Grandmother |  |  |  |  |  |  |  |
| Maternal Aunt |  |  |  |  |  |  |  |
| Maternal Aunt |  |  |  |  |  |  |  |
| Maternal Aunt |  |  |  |  |  |  |  |
| Pat. Grandmother |  |  |  |  |  |  |  |
| Paternal Aunt |  |  |  |  |  |  |  |
| Paternal Aunt |  |  |  |  |  |  |  |
| Paternal Aunt |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |
| Mat. Grandfather |  |  |  |  |  |  |  |
| Maternal Uncle |  |  |  |  |  |  |  |
| Maternal Uncle |  |  |  |  |  |  |  |
| Pat. Grandfather |  |  |  |  |  |  |  |
| Paternal Uncle |  |  |  |  |  |  |  |
| Paternal Uncle |  |  |  |  |  |  |  |
| Maternal cousin |  |  |  |  |  |  |  |
| Paternal cousin |  |  |  |  |  |  |  |
| Other relatives: |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

I have filled out these forms to the best of my knowledge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s signature)

I have reviewed all 3 pages of this patient’s medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marie F. Pennanen, MD/Lori C. Zorc, RN, ANP-BC