Patient Name:________________________

General Surgery

Tiffani Shelton, DO

CLINIC USE ONLY:

HT: ________ WT: __________

BP: ________ Pulse: _________

O2: ________ Temp: ________

Intake Questionnaire

We wish to ensure that our history and records are as complete and accurate as possible. Before you see the surgeon, please take a few minutes to fill out this intake questionnaire. We greatly appreciate your time.

Reason for Today's Visit:____

ALLERGIES to Medications	Reaction

MEDICATION LIST: Please list any medications that you are currently taking.

MEDICATIONS	DOSAGE		MEDICATIONS	DOSAGE

FAMILY MEDICAL HISTORY: Please list the major medical problems of all first and second degree relatives

Relative	Mother / Father's side (M or F)	Cancer Type	Age at Diagnosis	Living(current age) or Deceased? (year)

Patient Name:________________________

SOCIAL HISTORY:

Do you smoke? ❑ Yes ❑ No If so, how many packs/day & how long?_____________
Have you smoked in the past? ❑Yes ❑No If so, how many packs/day & how long?_______
Year you quit?________

Do you drink alcohol? ❑ Yes ❑ No If so, how many alcoholic beverages do you drink per week?_______________

Caffeine intake: None Occasional Daily (Moderate/Heavy)

Level of Education: High School 2 yr College 4yr College Postgraduate

Exercise Level: None Occasional Moderate Heavy

Employed? ❑ Yes ❑ No Occupation/Retired (previous occupation): _________________________

Do you or have you ever used **IV drugs** or other street drugs?_________________________

Marital Status: ❑ single ❑ married ❑ domestic partner ❑ widow(er) ❑ divorced

Do you live alone? ❑ Yes ❑ No If NO, with whom do you live?_____________________

Surgical History

Prior Surgeries	Year		Prior Surgeries	Year

PAST MEDICAL HISTORY:

Disorder:			Disorder:	
Anemia	Yes NO		Liver Disease	Yes NO
Anxiety	Yes NO		Pulmonary Embolism	Yes NO
Arthritis	Yes NO		Reflux/GERD	Yes NO
Asthma	Yes NO		Seizures/Epilepsy	Yes NO
Autoimmune Disease	Yes NO		Stroke	Yes NO
Bleeding Disorder	Yes NO		Other: (list below)	
Bronchitis	Yes NO			
COPD	Yes NO			
Cancer	Yes NO			
Coronary Artery Disease	Yes NO			
Deep Vein Thrombosis	Yes NO			
Depression	Yes NO			
Diabetes	Yes NO			
Diverticulitis	Yes NO			
Headaches	Yes NO			

Patient Name:_______________________

Patient Presenting for Breast Concern:

Age at Menarche (first period):________

Age of Menopause?__________ or (N/A) Hysterectomy? ❑ Yes ❑ No Why?__________

Age of First Pregnancy?_______ # times have you been pregnant?_____ How many births?_____

Did you breastfeed? ❑ Yes ❑ No If YES How Long?________

Current or past oral contraceptive pill use? ❑ Yes ❑ No How many years?_________
Current or past hormone replacement therapy (estrogen or progesterone)? How long?____
Personal History of Fertility treatments? ❑ Yes ❑ No

Do you perform self-breast exams? ❑ Yes ❑ No Note abnormalities:_______________

Genetic Testing:
Has any family member tested positive for Gene Mutations (BRCA1, BRCA 2, Li Fraumeni, Cowden's Syndrome, Familial adenomatous polyposis(FAP), Lynch,CDH1), HNPCC) ❑ Yes ❑ No
If YES who and please explain:____

Self or 1st Degree relative	Normal Mammogram? When?	Breast biopsy? Result	Age Diagnosed	Age @ death (if deceased)
Self	N/A Yes No Year:	N/A Benign DCIS Cancer		N/A
	N/A Yes No Year:	N/A Benign DCIS Cancer		
	N/A Yes No Year:	N/A Benign DCIS Cancer		
	N/A Yes No Year:	N/A Benign DCIS Cancer		
	N/A Yes No Year:	N/A Benign DCIS Cancer		

Personal History of Breast Cancer Treatment:

❑ Yes ❑ No Lumpectomy ❑ Right ❑ Left ❑ Bilateral ❑ Year:
❑ Yes ❑ No Mastectomy ❑ Right ❑ Left ❑ Bilateral ❑ Year:
❑ Yes ❑ No Sentinel Lymph node Biopsy ❑ Right ❑ Left ❑ Bilateral ❑ Year:
❑ Yes ❑ No Axillary Node dissection ❑ Right ❑ Left ❑ Bilateral ❑ Year:
❑ Yes ❑ No Radiation ❑ Right ❑ Left ❑ Bilateral ❑ Year:
❑ Yes ❑ No Chemotherapy