LONG ISLAND BREAST CARE- ***A DIVISION OF PROHEALTH CARE ASSOCIATES, LLP***
1010 NORTHERN BLVD, SUITE 102, GREAT NECK, NY 11021 (516) 487-8888

PATIENT HEALTH RECORD

Please PRINT all the information below as accurately as possible

NAME (PRINT)_____ DOB:_____ DATE:_____

WHO REFERRED YOU TO THIS OFFICE?_____

ACCOMPANIED BY:_____

CHIEF COMPLAINT:

PLEASE DESCRIBE WHY YOU ARE HERE TODAY IN YOUR OWN WORDS?

_____

_____

GENERAL MEDICAL HISTORY:

SIGNIFICANT MEDICAL CONDITIONS: ☐ NONE_____

_____

_____

CURRENT MEDICATIONS: ☐ NONE_____

_____

_____

OPERATIONS: ☐ NONE_____

_____

ALLERGIES: ☐ NONE_____

PAST FAMILY HISTORY:

FAMILY HISTORY OF BREAST OR OVARIAN CANCER (PLEASE LIST RELATIVE/APPROX AGE DIAGNOSIS)

MOTHER'S SIDE _____

FATHER'S SIDE_____

BRCA TESTING (YOU OR FAMILY)_____ ASHKENAZI JEWISH?_____

REVIEWD BY RN: _____ **REVIEWED BY MD:_____**

PAST BREAST/GYN HISTORY:

PREVIOUS BREAST PROBLEMS _____

_____

PREVIOUS NEEDLE BIOPSIES DIAGNOSIS	SIDE	DATE	WHERE	DOCTOR	

PREVIOUS BREAST SURGERY: DIAGNOSIS	SIDE	DATE	WHERE	DOCTOR	

DATE MOST RECENT MAMMOGRAM _____WHERE _____

DATE MOST RECENT SONOGRAM _____WHERE _____

DATE MOST RECENT MRI _____WHERE _____

DATE MOST RECENT BREAST PHYSICAL EXAM _____BY WHOM _____

DO YOU DO BREAST SELF EXAMS _____LAST EXAM BY PHYSICAN _____

AGE OF FIRST MENSTRUAL PERIOD _____DATE OF LAST MENSTRUAL PERIOD _____ ☐ NOW

AGE OF FIRST PREGNANCY _____AGE AT BIRTH OF FIRST CHILD _____

HOW MANY LIVE BIRTHS _____ MISCARRIAGES?_____TERMINATIONS?_____ECTOPICS _____

HOW MANY CHILDREN DID YOU BREAST FEED _____FOR HOW LONG _____

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS _____FOR HOW LONG _____

HAVE YOU EVER TAKEN HORMONE MEDICATION OF ANY TYPE? Y /N (*INCLUDES PILLS, CREAMS AND INJECTIONS)*

DRUG/DURATION OF USE_____

DO YOU TAKE SOY SUPPLEMENTS OR VITAMINS/HERBS OF ANY TYPE? IF YES, PLEASE DESCRIBE _____YES _____NO

IF YES, PLEASE

LIST:_____

SOCIAL HISTORY:

OCCUPATION: _____MARITAL STATUS: ☐S ☐M ☐D ☐W

LIST AMOUNT CONSUMED:

COFFEE _____CUPS/DAY

TEA _____CUPS/DAY

SODA _____GLASS/DAY

ALCOHOL _____GLASSES /WK

FOR_____ YEARS

CHOCOLATE _____ X PER DAY /MONTH/YEAR

DO YOU ADD SALT TO FOOD WHEN EATING/COOKING ☐YES ☐NO

DO YOU EXERCISE ☐ YES ☐ NO

_____TIMES PER WEEK FOR ___MINUTES PER SESSIONS

CIGARETTES? Y / N _____PACKS/DAY FOR _____ YEARS QUIT_____YEARS AGO REC. DRUGS _____

REVIEWD BY RN: _____ **REVIEWED BY MD:**_____

REVIEW OF SYSTEMS:

HEIGHT:_____ **WEIGHT:_____** **(YOU MUST FILL IN BOTH)**

LAST PAP: _____LAST COLONOSCOPY:_____LAST BONE DENSITY:_____SKIN CHECK :_____
month/year month/year month/year

PLEASE CHECK YES OR NO AND EXPLAIN

CONDITION	YES	NO	IF YES, PLEASE EXPLAIN
RECENT FEVERS OR WEIGHT/APPETITE CHANGE NIGHT SWEATS/HOT FLASHES	☐	☐	
EYE , EARS, NOSE /THROAT PROBLEMS (DOUBLE VISION, TEARING, NOSELEEDS, HOARSNESS)	☐	☐	
HEART OR CIRCULATION PROBLEMS	☐	☐	
• Hx of Heart Attack	☐	☐	
• Congestive Heart Failure	☐	☐	
• Heart Murmur/Mitral valve prolapse	☐	☐	
• Circulation problems/blot clots	☐	☐	
• High blood pressure	☐	☐	
BREATHING PROBLEMS (SHORTNESS, WHEEZING, COUGH)	☐	☐	
• Asthma/Emphysema	☐	☐	
• Hx of Pneumonia/bronchitis	☐	☐	
STOMACH/INTESTINAL PROBLEMS (DIFFICULTY SWALLOWING, GAS, PAIN)	☐	☐	
• Liver disease	☐	☐	
• Indigestion/reflux/ulcers	☐	☐	
• Colitis/Irritable bowel /diarrhea	☐	☐	
KIDNEY, BLADDER OR GENITAL PROBLEMS	☐	☐	
• Uterine / Ovarian / Prostate disease	☐	☐	
• Kidney disease / Stones	☐	☐	
• UTI or bladder infections / Frequency	☐	☐	
• Change in menses, irreg. Bleeding	☐	☐	
PROBLEMS WITH MUSCLES / JOINTS ***(BONE PAIN, JOINT PAIN, LEG CRAMPS)***	☐	☐	
PROBLEMS WITH SKIN / SKIN CANCER ***(RASH, LESIONS, ABNOMRAL GROWTHS)***	☐	☐	
PROBLEMS WITH BRAIN / SPINAL CORD ***(HEADACHE DIZZINESS, WEAKNESS, NUMBNESS)***	☐	☐	
• Stroke	☐	☐	
• Seizures	☐	☐	
• Fainting	☐	☐	
• Migraines	☐	☐	
PSYCHIATRIC PROBLEMS	☐	☐	
• Depression	☐	☐	
• Anxiety	☐	☐	
THYROID PROBLEMS / DIABETES	☐	☐	
BLEEDING DISORDERS	☐	☐	
INFECTIOUS DISEASES	☐	☐	
• OTHER- PLEASE DEFINE	☐	☐	

REVIEWED BY RN:_____ **REVIEWED BY MD:_____**

)

EMERGENCY CONTACT/REFERRING PHYSICIAN INFORMATION

PATIENT NAME: _____

EMERGENCY CONTACT: _____

HOME PHONE_____

CELL PHONE _____

RELATIONSHIP TO PATIENT _____

INTERNIST

FIRST & LAST NAME: _____

STREET ADDRESS_____

CITY_____ STATE_____ZIP CODE_____

PHONE #_____FAX# _____

GYN

FIRST & LAST NAME_____

STREET ADDRESS_____

CITY_____STATE_____ZIP CODE_____

PHONE#_____FAX#_____

MEDICATION LIST

Date _____

PATIENT: _____ **DOB:**_____

ALLERGIES: ❑ **NKDA or**
List_____

List all prescribed and over the counter medications, supplements, herbs, salves and ointments. Remember to update with start & stop date. If exact date is not known, enter approximate date or "UNKNOWN"
If no medications taken, please write "NONE" on top line under Medication Name.

Medication Name	Dose	Frequency	Route / Method Taken (oral,inject,etc)	Date Started	Date Stopped