

Cedar Valley Medical Specialists
Breast Care Center

Medical History Questionnaire

We need to know your past medical history to best understand how we can help you. All Information is confidential, and will not be released to anyone, unless requested by you in writing.

1. What is your full name? _____

2. Why are you here today? _____

3. Who referred you? _____

4. Do you take medications? ___No ___Yes Please list _____

5. Do you take blood thinners or any aspirin products? ___No ___Yes Please list: _____

6. Drug Allergies? ___No ___Yes Please List _____

7. Previous Operations? ___No ___Yes Please list _____

8. Previous Hospitalizations ___No ___Yes for what? _____

9. Please circle illnesses or conditions that you have had.

Diabetes Cancer Stroke Heart Trouble High Blood Pressure Hepatitis Gout
Kidney Disease Bleeding Tendencies Tuberculosis Asthma Pneumonia Broken Bones

Other: _____

10. Please circle illnesses which have occurred in any of your blood relatives.

Diabetes Cancer Stroke Heart Disease High Blood Pressure Bleeding Tendencies
Kidney Disease Tuberculosis Other: _____

11. Do you smoke? ___No ___Yes Amount: _____

12. Do you drink alcohol? ___No ___Yes Amount: _____

13. Have you ever had a blood or blood product transfusion? ___No ___Yes Year: _____

14. Have you ever had an unusual reaction to any general or local anesthetic? ___No ___Yes
Explain: _____

15. Have you been tested for HIV (AIDS) ___No ___Yes
Have you ever used intravenous drugs (street drugs) ? ___No ___Yes

16. Is there any other information about your health, which the doctor should know? _____

Reviewed by Physician _____ Date _____