PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few moments to completely fill out this form as accurately as possible. All fields are mandatory. If you have questions, we will be happy to help you.

Last Name:	First Name:	Middle Name:	
Street Address:	City & State:	Zip:	Marital Status:
Home Phone:	Work Phone:	Cell Phone:	Driver's Lic. #
( )	( )	( )	

Date of Birth:	Social Security #	Occupation:
Employer Name:	Employer's Address and Phone:	

Primary Care Doctor: (Name, Address and Phone)

Whom may we thank for referring you?

☐ Patient ☐ Physician ☐ Magazine ☐ Hospital ☐ Internet ☐ Other (please list details below)

E-Mail Address: (personal and/or work)

Emergency Contact:	Relationship to patient & Phone Number
	( )
Is anyone other than you responsible for payment?	If yes, please provide: Name, Relationship to patient & Phone Number
☐ YES ☐ NO	

Patient Signature: **Click here to print and bring with you** Date:

Health Questionnaire

Date _____/___/_____

Name_____ Referred by_____

Date of Birth___/__/_____ Age_____ Occupation_____

What are you coming in for today?_____

Weight:_____lbs Height:_____ Current bra size:_____ Desired bra size:_____
# of children:_____ C-sections: Y or N Did you breast feed?_____
**RECENT WEIGHT LOSS: _____lbs Weight at your heaviest: _____lbs

Breast Reductions: Backaches?[ ] Neckaches?[ ] Headaches?[ ] Bra-strap shoulder grooves?[ ] Breast rashes?[ ] Tingling in your arms?[ ] Decreased ability to exercise?[ ]
What have you tried to relieve the above problems?_____

List all medications you are taking:
Anything you ingest that isn't a food*

_____
_____
_____
_____
_____
_____
_____

Do you take any of the following:

Aspirin/Excedrin.....	Yes[ ]	No[ ]
Ibuprofen/Advil/Motrin…	Yes[ ]	No[ ]
Vitamin E/Multi Vit.....	Yes[ ]	No[ ]
Herbal Remedies.....	Yes[ ]	No[ ]
Tylenol/Acetaminophen.	Yes[ ]	No[ ]
Green Tea…….	Yes[ ]	No[ ]
Fish oil/Omegas/Flax seed	Yes[ ]	No[ ]

List all hospitalizations, operations (including plastic surgery, biopsies or childhood surgeries) **and serious injuries:**

Year	Surgery-Hospitalization-Injury
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

	yes	no	effect
Penicillin.....	[ ]	[ ]	_____
Latex.....	[ ]	[ ]	_____
Other antibiotics…....	[ ]	[ ]	_____
Iodine.....	[ ]	[ ]	_____

Nausea/vomit w/ pain meds? Y or N

Illness & Medical Problems

	Yes	No		Yes	No
Anemia……	[ ]	[ ]	Ulcer.....	[ ]	[ ]
High Blood pressure..	[ ]	[ ]	Bowel problems.....	[ ]	[ ]
Bleed/Bruise Easily....	[ ]	[ ]	Headaches …….....	[ ]	[ ]
Constipation…….	[ ]	[ ]	DVT/Pulmonary Embolus	[ ]	[ ]
Bleeding disorder.....	[ ]	[ ]	Hepatitis.....	[ ]	[ ]
Heart Attack.....	[ ]	[ ]	Convulsions/seizures..	[ ]	[ ]
Heart murmur.....	[ ]	[ ]	Asthma.....	[ ]	[ ]
Autoimmune disorder	[ ]	[ ]	Rheumatologic disorder	[ ]	[ ]
Diabetes.....	[ ]	[ ]	Emphysema.....	[ ]	[ ]
Trouble with anesthesia	[ ]	[ ]	Pneumonia/bronchitis...	[ ]	[ ]
Arthritis.....	[ ]	[ ]	Dry eyes.....	[ ]	[ ]
Anxiety disorder.....	[ ]	[ ]			

Women only:

Breast biopsies?.....Y or N

Last Mammogram date _____

Results _____

History of breast cancer? Y or N

Family History (mom, dad, brother, sister)

	Yes	No
Blood Disorders.....	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Diabetes.....	[ ]	[ ]
DVT/Pulmonary embolus...	[ ]	[ ]
Cancer.....	[ ]	[ ]
Breast Disease…..	[ ]	[ ]

Social History

1) Marital Status [ ]Married [ ]Single [ ]Sig. other [ ] Widowed
2) Use of Drugs? [ ] Never [ ] Type & freq_____
3) Use Alcohol? [ ] Never [ ] Occasional [ ] Daily
4) Use Tobacco/Nicotine Products?

[ ] Never [ ]Not Now [ ] Yes, currently

packs per day_____ # of Years? _____

Signature of Patient or Guardian X_____ Reviewed by_____