Saint John's Health Center
PROVIDENCE Health & Services

JOHN WAYNE CANCER INSTITUTE
at Providence Saint John's Health Center

Margie Petersen Breast Center

Medical History Questionnaire

Date: _____

Name: _____ Sex: ☐ Female ☐ Male
Last First Middle

Date of Birth: _____ Age: _____

Marital Status: ☐ Single ☐ Married/Partnered (how long) _____ ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ White/Caucasian ☐ Black/African-American ☐ Native Hawaiian or other Pacific Islander
☐ Ashkenazi Jewish Heritage ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic/Latina
☐ Other: _____

Address: _____

Home Phone: _____
Cell Phone: _____
Email: _____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email

Occupation: _____

If retired or disabled, since when? _____

Referring Physician:

1) Name: _____

Primary Care Physician:

2) Name: _____

We would like to know how you selected the **Margie Petersen Breast Center at Providence Saint John's Health Center:**

☐ My physician recommended I come
☐ I asked my physician to refer me
☐ I referred myself
☐ A friend or relative referred me
☐ Other: _____

History of your present health problem or illness for which you are seeking care at the Margie Petersen Breast Center at Providence Saint John's Health Center:

Please describe briefly, in your own words, the date of onset of your current problem or illness, any symptoms you have experienced, and the dates of any tests and/or treatment(s), with the names and addresses of physicians whom you have consulted.

Do you have any conditions related to the following categories? If so, please describe and date.

Eyes, Ears, Nose: _____

Throat: _____

Lungs: _____

Heart/ Cardiac: _____

Abdomen: _____

Musculoskeletal: _____

Neurologic/Fatigue/Forgetfulness: _____

Skin: _____

Endocrine/Thyroid: _____

Hematology/Bleeding: _____

Gynecological/Urology: _____

Psychologic: _____

Other: _____

Are you experiencing pain at this time? ☐ **Yes** ☐ **No**
Please rate on a scale of 0-10, your level of pain:_____
(0: no pain, 10: worst pain you have ever felt)

Do you drink alcohol? ☐ **Yes** ☐ **No** **How many drinks, on average, per week?** _____

Do you smoke cigarettes? ☐ **Yes** ☐ **No** **If yes, how many packs per day?** _____

Do you smoke e-cigarettes? ☐ **Yes** ☐ **No**

Recent weight gain or loss? ☐ **Gained** _____**lbs** ☐ **Lost** _____**lbs**

Do you drink caffeine? ☐ **Yes** ☐ **No** **If yes, what type and how often?** _____

Past breast problems (abnormal imaging, biopsies, and surgeries):

Right/Left Side Type of Problem When

Have you ever taken hormones? ☐ Yes ☐ No ☐ Don't Know

Hormone	When started?	When stopped?
Birth Control Pills		
Estrogen		
Tamoxifen		
Evista (Raloxifene)		
Other:		

Age of onset of menstruation: _____

Have you gone through menopause? If so, at what age? _____

Interval between periods: _____

Duration of periods: _____

Date of last period: _____

Number of pregnancies: _____

Number of births: _____

Number of miscarriages: _____

Number of abortions: _____

Age at first childbirth: _____

Did you breastfeed? If so, how long? _____

Family history of Breast or Ovarian cancer: (If so, who, relation, and what?) _____

Condition	Date, if yes	Yes	No	Do Not Know
Vaginal Bleeding				
Painful menstruation				
Irregular or excessive menstruation				
Vaginal discharge				
IUD				
Gone through menopause				

Past Surgery/ Operations:
Please list in chronological order

MONTH	YEAR	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Chronic Medical Problems:

DESCRIPTION	YEAR DIAGNOSED	TREATMENT	DOCTOR

Other Hospitalizations:
Please list in chronological order

MONTH	YEAR	TYPE	HOSPITAL	DOCTOR

Are you allergic to any medicines? ☐ Yes* ☐ No

*Please list any medications to which you have had an allergic reaction, and the type of reaction:

_____

_____

_____

Are you allergic to any foods? ☐ Yes* ☐ No

*Please list any foods to which you have had an allergic reaction, and the type of reaction:

_____

_____

_____

Please list any medications you are currently taking:

	Name of Medication	Dosage	Frequency
Hormones or Birth Control Pills:			
Antidepressant/Antianxiety Pills:			
Tranquilizers/Sleeping Pills:			
Pain Pills:			
Other:			

Please list or describe any other therapies, vitamins, or herbal remedies you are taking currently, why & how you take each (such as frequency and amount): *(if you need more space, please continue on the back)*

Name of Vitamin, Herb or therapy	Purpose	Dosage & Frequency	When started

Past radiation therapy treatment:

Please list in chronological order.

We need to know when treatment started and when it was completed.

STARTED?		STOPPED?		AREA OF BODY TREATED	HOSPITAL	DOCTOR
Month	Year	Month	Year			

Family History

Have any of your blood relatives (both mother's and father's sides), spouse, or children had:

Yes	No	(CHECK EACH ITEM)	RELATION(S)
☐	☐	Tuberculosis	
☐	☐	Diabetes	
☐	☐	Cancer ☐ Breast..... ☐ Ovarian..... ☐ Colon..... ☐ Prostate..... ☐ Other	
☐	☐	Leukemia	
☐	☐	Anemia	
☐	☐	Bleeding Tendency	
☐	☐	Heart Disease	
☐	☐	High Blood Pressure	
☐	☐	Kidney Disease	
☐	☐	Asthma, Hay Fever, Other Allergy	
☐	☐	Chronic Arthritis (Rheumatism)	
☐	☐	Nervous Or Mental Disorder	
☐	☐	Goiter	
☐	☐	Emphysema	
☐	☐	Any Other Illness	