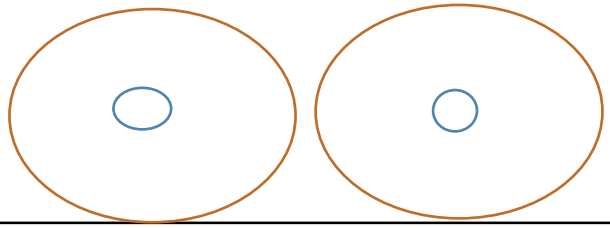
LANETTE F. SMITH, M.D.
Breast Surgery of Tulsa
1836 E. 15th Street
Tulsa, OK 74114
Phone: 918-585-5658
Fax: 918-585-5670

NEW PATIENT HISTORY

PATIENT - NAME IN FULL	○ M ○ F	AGE	DATE OF BIRTH	HAVE YOU SEEN DR. SMITH IN THE PAST? Yes No Year:

YES	NO	BREAST HISTORY
		Do you have a **breast lump, thickening**, or **tissue changes**? *If yes, describe the problem and mark the area of your concern on the diagram:*

Right  Left

		Do you have any **nipple discharge**? *If yes, describe*:
		Do you have any **breast pain**? *If yes, describe*:
		Have you been previously treated for **breast cancer**? *If yes, when and at what facility?*
		Have you ever had a **biopsy** of your breasts? *When and where was the procedure performed?*
		Have you ever had a **mammogram**? *When and where was the procedure performed?*
		Have you ever had an **abnormal mammogram**? *If yes, describe:*
		Do you perform monthly self breast examinations?
		Do you have **breast implants**? *If yes, when*: *Specify bra size*:

YES	NO	MENSTRUAL HISTORY
		If you have a period, is it regular?
		Have you ever taken birth control pills?
		Have you experienced menopause? ***If yes, at what age****?*
		Have you had a hysterectomy (removal of the uterus)?
		Do you still have ovaries?
		Are you on any hormone replacement therapy (prescription or non)? *If yes, what kind?* ***How long have you been taking it?***

AGE AT FIRST PERIOD	DATE OF LAST MENSTRUAL PERIOD	AGE AT FIRST CHILDBIRTH
NUMBER OF PREGNANCIES	NUMBER OF LIVE BIRTHS	NUMBER OF MISCARRIAGES/ABORTIONS

YES	NO	SOCIAL HISTORY
		Do you smoke or use tobacco products? *If yes, how many packs per day*? *How many years?*
		Do you use alcohol? *If yes, how many servings per day*?
		Do you use street drugs? *If yes, which one(s) and how often?*
		Do you currently endure any unusual stress in your life?
		Are you frequently exposed to dangerous or toxic chemicals? *If yes, which one(s) and how often?*

Including yourself, how many people currently reside in your home?

Marital Status: *circle one* Single Married Divorced Widowed

What is the highest level of education you have completed?

What is your average daily level of exercise?

Caffeine Intake (Servings Per Day)	COFFEE	TEA	COLA	CHOCOLATE

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PAST MEDICAL HISTORY - CIRCLE ALL THAT APPLY

AIDS	Cataracts	Hepatitis	Mononucleosis
Alcoholism	Chemical Dependency	Hernia	Multiple Sclerosis
Anemia	Chicken Pox	Herpes	Pacemaker
Anorexia	Depression	High Cholesterol	Pneumonia
Anxiety	Diabetes	HIV Positive	Polio
Appendicitis	Emphysema	Hypertension	Psychiatric Care
Arthritis	Endometriosis	Kidney Disease	Stroke
Asthma	Fibromyalgia	Lactose Intolerance	Suicide Attempts
Bleeding Disorders	Glaucoma	Liver Disease	Thyroid Problems
Bronchitis	Gonorrhea	Measles	Tonsillitis
Bulimia	Gout	Migraine Headaches	Tuberculosis
Cancer, *type:*	Heart Disease	Mitral Valve Prolapse	Ulcers

LIST ANY OTHER ILLNESS:

PAST SURGICAL HISTORY

YEAR	HOSPITAL	REASON FOR TREATMENT AND OUTCOME

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	DOSAGE	MEDICATION	DOSAGE

LIST ALL ALLERGIES

SUBSTANCE	REACTIONS

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REVIEW OF SYSTEMS

PLEASE CHECK HERE AND SIGN IF ALL NEGATIVE ☐ **PATIENT SIGNATURE** _____

PATIENT - NAME IN FULL	○ M ○ F	DATE OF BIRTH	AGE	DATE OF VISIT

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW OR IN THE PAST

PAST	NOW	GENERAL	PAST	NOW	CARDIOVASCULAR	PAST	NOW	MUSCLE/JOINT/BONES
		Chills			Chest Pain			Pain/Weakness/Numbness in:
		Dizziness			Heart Murmur			Arms
		Fainting			High Blood Pressure			Back
		Fatigue			Irregular Heartbeat			Feet
		Fever			Low Blood Pressure			Hands
		Forgetfulness			Palpitations			Hips
		Loss of Sleep			Poor Circulation			Legs
		Sudden Weight Loss			Rapid Heartbeat			Neck
		Sweats			Swelling of Ankles			Shoulders
PAST	**NOW**	**EYE**			Varicose Veins			
		Blurred Vision	**PAST**	**NOW**	**GASTROINTESTINAL**	**PAST**	**NOW**	**SKIN**
		Crossed Eyes			Bloating			Changes in Moles
		Double Vision			Bowel Changes			Hives
		Vision Flashes			Constipation			Itching
		Vision Halos			Diarrhea			Rash
PAST	**NOW**	**ENT/MOUTH**			Excessive Hunger			Scars
		Bleeding Gums			Gas			Sores that won't heal
		Difficulty Swallowing			Hemorrhoids			
		Ear Discharge			Indigestion	**PAST**	**NOW**	**HEMATOLOGIC**
		Earache			Nausea			Bruise Easily
		Hay Fever			Poor Appetite	**PAST**	**NOW**	**ENDOCRINE**
		Hoarseness			Rectal Bleeding			Diabetes
		Loss of Hearing			Stomach Bleeding			Excessive Thirst
		Nosebleeds			Vomiting			Thyroid Problems
		Ringing in Ears			Vomiting Blood	**PAST**	**NOW**	**PSYCHIATRIC**
		Sinus Problems						Anxiety
		Sore Throat	**PAST**	**NOW**	**GENITOURINARY**			Depression
PAST	**NOW**	**RESPIRATORY**			Blood in Urine			Nervousness
		Coughing up Blood			Frequent Urination	**PAST**	**NOW**	**NEUROLOGIC**
		Persistent Cough			Lack of Bladder Control			Headache
		Shortness of Breath			Painful Urination			Numbness
		Wheezing						Stroke

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FAMILY HISTORY

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH BREAST CANCER?

FAMILY MEMBER	MATERNAL	PATERNAL	AGE AT DIAGNOSIS	
				UNILATERAL BOTH
				UNILATERAL BOTH
				UNILATERAL BOTH
				UNILATERAL BOTH
				UNILATERAL BOTH

LIST ANY OF YOUR FAMILY MEMBERS WHO HAVE BEEN DIAGNOSED WITH THESE ILLNESSES:

ILLNESS	FAMILY MEMBER	MATERNAL	PATERNAL	AGE AT DIAGNOSIS
OVARIAN CANCER				
UTERINE CANCER				
ENDOMETRIAL CANCER				
COLON CANCER				
PROSTATE CANCER				
MELANOMA				
PANCREATIC CANCER				
HEART DISEASE				
DIABETES				
GLIOBLASTOMA				

Have you undergone genetic testing in the past? YES NO

If yes, where and when was genetic testing performed?

Have any of your family members undergone genetic testing? YES NO UNKNOWN

If yes, where and when was genetic testing performed?

Do you have any particular ethnic background that may influence your genetic risk? YES NO

If yes, please specify: