

Today's Date:

____/____/____

Patient Name:

Date of Birth: ____/____/____

Medical History: ____ Unremarkable ____ Diabetes Mellitus ____ Asthma ____ COPD ____ Stroke
____ Coronary Artery Disease ____ Peptic Ulcer Disease ____ HIV ____ Kidney Disease
____ Cholesterol ____ Hyperthyroid ____ Hypothyroid ____ Congestive Heart Failure
____ Hypertension ____ Myocardial Infarction ____ Other _____

If cardiac history, please list contact information for your cardiologist:

Dr. _____ Phone #: _____

Surgical History: ____ Unremarkable ____ Appendectomy ____ Gallbladder Removal ____ Colon
____ Coronary Artery Bypass Graft ____ Valve ____ Hysterectomy ____ Tubal Ligation
____ Hernia Repair (**Circle**) Ventral Incisional Umbilical Left Inguinal Right Inguinal Epigastric
____ Bilateral Salpingo-Oophorectomy ____ Caesarean Section ____ Other _____

Social History: Smoke: Y ____ N ____ ____ pks/day for ____ # years Quit ____ Mth(s)/Yr(s) Ago
Alcohol: Y ____ N ____ ____ day/week ____ Occasionally ____ Rare

Breast Evaluation: (complete ONLY if you are being evaluated for a breast related issue, otherwise skip)

____ Age of Menarche ____ Age of Menopause ____ Age at First Delivery
Breast Feeding History: Y ____ N ____
Breast Cancer Family History : Y ____ N ____ Relationship: _____ Age of Diagnosis:
____ (mother/grandmother/sister, etc.)
Hormone Replacement History: Y ____ N ____
Previous Breast Biopsy: Y ____ N ____ Date: ____/____/____

Hernia Evaluation: (complete ONLY if you are being evaluated for a hernia related issue, otherwise skip)

Have you had any procedure (including dental) within the last 60 days? Y ____ N ____

If yes, when? _____ What procedure? _____

*If you are scheduled for a hernia repair, we recommend no further operations for 90 days from surgery date.

Devices: Shunt ____ Pacemaker ____ Stent ____ Defibrillator ____ Metal ____ Other ____