

Today's Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

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