**Intake Form**

**Past Medical History**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td>Endocarditis</td>
<td>Migraine Headaches</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>Gallbladder Disease</td>
<td>MRSA / VRE, Site:</td>
</tr>
<tr>
<td>Anemia</td>
<td>Acid Reflux</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Angina (Chest Pain)</td>
<td>Heart Attack</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>Heart Valve Disease</td>
<td>Peptic Ulcer Disease</td>
</tr>
<tr>
<td>Asthma /COPD</td>
<td>Hepatitis C</td>
<td>Problems with Anesthesia</td>
</tr>
<tr>
<td>Atrial Fibrillation / irregular heart beat</td>
<td>HIV/AIDS</td>
<td>Pulmonary Fibrosis</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>High Cholesterol</td>
<td>Radiation</td>
</tr>
<tr>
<td>Blood Clots /PE/DVT</td>
<td>High Blood Pressure</td>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Hyper / Hypo thyroidism</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Cancer, List type:</td>
<td>Irritable Bowel Disease</td>
<td>Stroke</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>Kidney/Liver Disease</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>Lupus (other connective tissue disease)</td>
<td>Other:</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Malignant Hyperthermia</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Past Surgical History**

(Please list the type of surgery and the year it was done.)

- 
- 
- 

**Review of Systems**

(Please circle any issues you are currently experiencing.)

**GENERAL**
- Fatigue
- Fever
- Night sweats

**CARDIOVASCULAR**
- Chest pain
- Leg pain
- Irregular Heart Beat

**METABOLIC/ENDOCRINE**
- Cold intolerance
- Heat intolerance
- Excessive thirst
- Extreme hunger

**HEAD AND NECK**
- Eye discharge
- Vision/Hearing Loss
- Ear/Nasal Drainage

**GASTROINTESTINAL**
- Abdominal pain
- Constipation
- Diarrhea
- Vomiting

**NEURO/PSYCHIATRIC**
- Unsteadiness
- Psychiatric symptoms

**RESPIRATORY**
- Cough
- Difficulty Breathing
- Wheezing

**GENITOURINARY**
- Painful urination
- Blood in urine
- Urinary frequency
- Vaginal Discharge

**SKIN/BREAST**
- Breast pain
- Breast discharge
- Itching
- Rash

**MUSCULOSKELETAL**
- Bone/joint pain
- Weakness

**HEMATOLOGY**
- Bleeding
- Easy bruising

Use of alcohol (circle one) Never Rarely Socially Daily Type:_______

Use of tobacco (circle one) Never Rarely Socially Daily Type:_______

Caffeine intake (circle one) Never Rarely Occasionally Daily Type:_______ Cups per day:_______
Allergies
(Please list any medication, environmental or food to which you have a known allergy.)
(Or circle: NO KNOWN ALLERGIES)

_________________________________________  __________________________________________

Breast History

Current Breast Problems (Reason for visit today):_________________________________________

_________________________________________  __________________________________________

Age of first period:________ Date last menstrual period began:________ Age at Menopause:_______
Total number of pregnancies:________ Number of live births:________ Age at first live birth:________
Did you breastfeed?________ How long for each child?________________________________________
Date of last mammogram:_______________ Date of last pap smear/GYN exam:_____________________
Have you ever had surgery or a biopsy on the breasts? (Circle one) YES NO
If yes, please indicate what procedure you had, what the results were and when the procedure took place:

_________________________________________  __________________________________________

Have you ever taken birth control pills? YES NO If yes, are you currently taking them? YES NO
Have you ever taken hormone replacement therapy or fertility drugs? YES NO
If yes, list names and duration:

_________________________________________  __________________________________________

Family History

Please list any blood relatives with history of the following. (Please list relation and age at diagnosis. Please also
distinguish between maternal and paternal relatives: i.e. “maternal aunt” or “paternal grandfather”)

Breast Cancer?

Ovarian Cancer?

Prostate Cancer?

Colon Cancer?

Other?

_________________________________________  __________________________________________

Is your family of Jewish decent? (Circle one) YES NO

Medications
(Please list all current medications, vitamins, supplements, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>