Hilton Head Regional Healthcare
Breast Health Center

NAPBC
NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS

Name _____ Date of Birth _____ Age _____
Address _____ SSN _____
Telephone _____Cell _____ Work _____
Email _____
Occupation _____ If retired, occupation before _____
Referring physician _____ Primary Care Physician _____
Gynecologist _____
Reason for visit _____
Have you ever had this problem before? Yes ____ No ____ Date of last mammogram _____
Pharmacy _____ Pharmacy Telephone _____

We ask race and ethnic background only to assess potential risk factors for breast cancer. If you feel uncomfortable answering the following two questions, please wait and talk to your physician.

Race: White ____ Black ____ Asian/Pacific ____ Native American ____ Unknown ____ Other _____
Ethnicity: Hispanic ____ Non-Hispanic ____ Other _____
Are your parents of Jewish descent? No ____ Yes ____ Which one? Mother ____ Father ____

Age at first menstrual period _____ Date of last menstrual period _____
Number of pregnancies ____ Number of children ____ Age at first live birth ____
Menopausal: Pre ____ Peri ____ Post____ If menopausal, date of onset _____
Have you had a hysterectomy? Yes ____ No ____ If yes, at what age? ____
Were ovaries removed? Yes ____ No ____
Have you taken birth control? Yes ____ No ____ Number of years ____ Currently using? Yes ____ No ____
Have you ever taken hormones replacement therapy? Yes ____ No ____ Number of years ____
Currently using? Yes ____ No ____ # of years since stopped ____
Have you ever had genetic testing? Yes ____ No ____ If so, results _____
Have any family members ever had genetic testing? Yes ____ No ____ If so, results _____

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BREAST SURGERY HISTORY: Operation/Date	Where was surgery done?	Result

SURGICAL HISTORY: Please list all surgeries/operations/dates of surgeries	Where was surgery done?

MEDICATIONS: Please include over the counter medications, vitamins and herbal medications

Medication	Dose	Reason for Medication

ALLERIGIES: Please list all types of allergies	Type of reaction

Alcohol use: # of drinks per day ____ Caffeine use: # of drinks per day ____
Do you smoke: No ____ Yes ____ if yes, how much _____ How long _____
Former smoker: No ____ Yes ____ how long _____ #packs/day when smoking ____
Smokeless Tobacco/vaping: No ____ Yes ____

LIST MEDICAL HISTORY:

_____
_____
_____
_____
_____
_____

Name _____ Date of Birth _____ Age _____

ARE YOU CURRENTLY HAVING ANY OF THESE SYMPTOMS:	YES/NO	IF YES, PLEASE EXPLAIN
General - appetite change, chills, weight loss, fever, unexpected weight loss		
HEENT- facial swelling, neck pain, sore throat, hearing loss, ear pain, dental problems, voice change		
Eyes - drainage, itching, redness, sensitivity to light		
Respiratory - shortness of breath, wheezing, coughing		
Cardiovascular - chest pain, leg swelling, palpitations		
GI - Abdominal distention, pain, diarrhea, nausea/vomiting, blood in stool		
Endocrine - heat/cold intolerance		
GU - flank pain, frequency, pelvic pain, pain with urination		
Musc - back pain, joint swelling, muscle pain		
Skin - color change, rash, wound		
Neuro - dizziness, numbness, seizures, tremors		
Hem - lymph node swelling, bleed/bruise easily		
Psych - agitation, anxiety, suicidal thoughts, confusion		

FAMILY *CANCER* HISTORY:

Mother's Side:			**Father's Side:**		
Type:	Relation to you:	Age at Diagnosis:	Type:	Relation to you:	Age at Diagnosis:

- I authorize the Breast Health Center to disclose/release information to:
  Name of individual(s):
  _____
  _____
  _____
  _____

I have reviewed this information with the patient:

_____ _____