HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

THE CENTER FOR BREAST HEALTH
5759 Cedar Lane, Columbia, MD 21044
410-884-4744 410-720-8213 (fax)

PATIENT INFORMATION SHEET:

Name:______________________________ Age:__________ Date:__________

Occupation:____________________ Level of Education:______________ Learning Disability: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

If needed, a good contact person and phone number to reach you:______________________________

Primary Care Doctor or Nurse Practitioner:______________________________

Other Providers:______________________________

Have you ever had a: Mammogram ☐ Yes ☐ No Breast ultrasound ☐ Yes ☐ No Breast MRI ☐ Yes ☐ No

Where:______________________________

Females only complete this section:

Age at first menstrual period:__________ Date of last menstrual period: ______________

Age at menopause:__________ If post-menopausal: ☐ Natural ☐ Surgical ☐ Chemo related

Number of pregnancies:________ Number of births:______ Age at first birth:______ Breast feed: ☐ No ☐ Yes

History of oral contraceptive use: ☐ No ☐ Yes History of fertility treatments: ☐ No ☐ Yes

History of hormonal replacement therapy: ☐ No ☐ Yes (Type______________ Dates______________)

MEDICAL HISTORY:

Reason for Visit: (please check all that apply)

☐ Breast lump ☐ Nipple discharge ☐ Skin changes ☐ Breast pain

☐ Abnormal mammogram ☐ Atypia/abnormal biopsy ☐ Breast cancer ☐ Other:______________

Previous personal history of breast cancer: ☐ No ☐ Yes

Family history of breast cancer: ☐ No ☐ Yes Who:______________________________

Family history of ovarian cancer: ☐ No ☐ Yes Who:______________________________

Previous radiation or chemotherapy treatment: ☐ No ☐ Yes

Previous genetic testing: ☐ No ☐ Yes Ashkenazi Jewish? ☐ No ☐ Yes BRCA: ☐ No ☐ Yes

SURGERIES AND PROCEDURES: ***(please check all that apply)***

Breast: ☐ Biopsy ☐ Aspiration ☐ Lumpectomy ☐ Mastectomy ☐ Implants ☐ Breast reduction
☐ Breast reconstruction Type:______________________________

Cardiovascular: ☐ Cardiac cath ☐ Cardiac bypass ☐ Heart valve ☐ Pacemaker ☐ Aneurysm ☐ Carotid
☐ Hemorrhoids ☐ Varicose veins ☐ Other:______________________________

GI: ☐ Appendix ☐ Colonoscopy ☐ Rectocele ☐ Gallbladder ☐ Other:______________________________

OB/GYN: ☐ Hysterectomy ☐ Ovaries ☐ D&C ☐ C-Section ☐ Tubal ligation ☐ Fibroids ☐ Exploratory laparotomy
☐ Other:______________________________

Urology: ☐ Kidneys ☐ Bladder ☐ Cystocele ☐ Prostate ☐ Other:______________________________

Head/Neck: ☐ Tonsils ☐ Sinuses ☐ Thyroid ☐ Eyes ☐ Ears ☐ Nose ☐ Wisdom teeth ☐ Other:______________

Ortho/Neuro: ☐ Back/spine ☐ Knee ☐ Hip ☐ Shoulder ☐ Carpal tunnel ☐ Other:______________

Other: ☐ Hernia ☐ Transplant ☐ Plastic surgery ☐ Bariatric Other:______________

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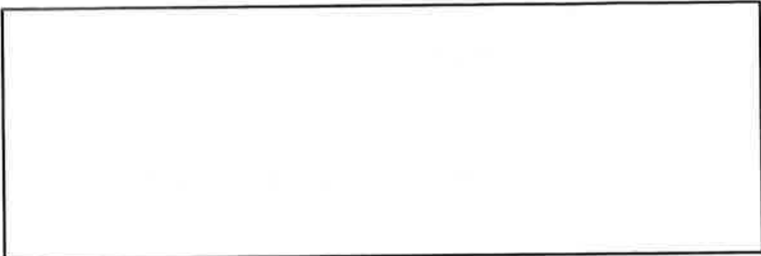

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PATIENT INFORMATION SHEET:

Review of Systems: (please check all symptoms that apply)

General: ☐ Weight gain ☐ Weight loss ☐ Chills ☐ Fatigue ☐ Night sweats

Pulmonary: ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Asthma ☐ COPD

Cardiac: ☐ Palpitations ☐ Irregular heart ☐ Chest pain ☐ Swelling in legs

GI: ☐ Indigestion/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea

Neuro: ☐ Numbness/Tingling ☐ Fainting/Dizziness ☐ Loss of coordination ☐ Headache
☐ Vision Problem ☐ Hearing problem ☐ Pain:______________________________

Bleeding: ☐ Easy bruising ☐ Unusual bleeding - Where?__________________ ☐ Clotting problems

Urinary: ☐ Frequency/Urgency/Burning ☐ Incontinence ☐ Difficulty with urination

Endocrine: ☐ Diabetes ☐ Thyroid disease ☐ Other:____________________________

Hematology: ☐ Anemia ☐ Bleeding ☐ Clotting ☐ DVT/PE ☐ Sickle Cell ☐ Other:__________________

Immunology: ☐ AIDS ☐ HIV ☐ Autoimmune disease:____________ ☐ Other:__________________

Musculoskeletal: ☐ Arthritis ☐ Muscle disorder ☐ Other:__________________________________

Past Medical History: *(Please check any of the conditions below that you have been treated for in the past)*

Cardio/Vascular: ☐ Angina/chest pain ☐ Heart attack ☐ Arrhythmia/A-fib ☐ Murmur/Valve disease
☐ High blood pressure ☐ High cholesterol ☐ Congestive heart failure ☐ Varicose veins
☐ Periperhal vascular disease ☐ Other:_________________________

Endocrine: ☐ Diabetes ☐ Thyroid disease ☐ Other:____________________________

Pulmonary: ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Sleep apnea ☐ TB ☐ Other:______________

GI/Hepatic: ☐ Reflux ☐ GI bleed ☐ Crohns ☐ Ulcerative colitis ☐ Hepatitis ☐ Cirrhosis ☐ Other:____________

Renal: ☐ Urinary tract infections ☐ Kidney disease ☐ Dialysis ☐ Kidney stones ☐ Other:______________

Neurology: ☐ Epilespy ☐ Seizures ☐ Stroke ☐ TIA ☐ Migraines ☐ Neuro disease:________________

Hematology: ☐ Anemia ☐ Bleeding ☐ Clotting ☐ DVT/PE ☐ Sickle Cell ☐ Other:__________________

Immunology: ☐ AIDS ☐ HIV ☐ Autoimmune disease:____________ ☐ Other:__________________

Psych: ☐ Anxiety/Panic ☐ Depression/Bipolar ☐ Dementia ☐ Drugs ☐ Alcohol abuse

Cancer(s):____

Other medical conditions:____

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Family Medical History (Please check all that apply)	No Known Problem	Cancer	Leukemia	Anemia	Arthritis	Asthma/COPD	Birth Defects	Premature Cancer	Coronary Artery Disease	Colon Cancer	BRCA 1/2	Diabetes	Drug Abuse	Early Death	Hearing Loss	HIV	Hyperlipiemia	Hypertension	Kidney Disease	Allergies	Malaria	Mental Illness	Miscarriage	Seizure/ Convulsions	Stroke	Vision Loss	Thyroid Disease	Other
Mother																												
Father																												
Sister																												
Brother																												
Daughter																												
Son																												
Mat Grandmother																												
Mat Grandfather																												
Pat Grandmother																												
Pat Grandfather																												
Mat Aunt																												
Mat Uncle																												
Pat Aunt																												
Pat Uncle																												
Other																												

MEDICATIONS, HERBS AND SUPPLEMENTS:

Drug	Dose	Frequency	Drug	Dose	Frequency

Drug allergies: ____________________

____

____

Environmental allergies (e.g. latex, foods, contrast dyes): ____________________

____

☐ Attached detailed medication list.

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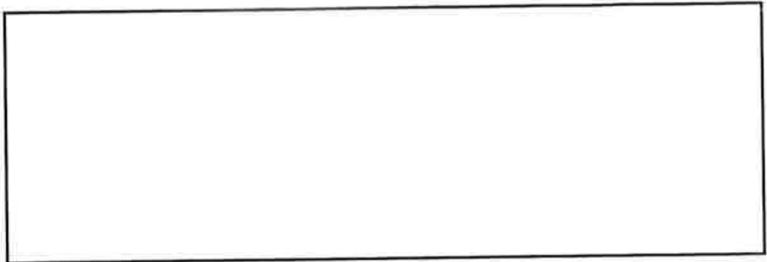

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PATIENT INFORMATION SHEET:

Please attach patient medication list below:

If other, please list here:____

Social History: ***(please check all that apply)***

Smoker: ☐ No ☐ Previous ☐ Yes - How much?____________________ How long?______________

Alcohol: ☐ No ☐ Previous ☐ Yes - How much?____________________ How long?______________

Substance abuse: ☐ No ☐ Previous ☐ Yes - Type____________________________________

Date:________ Time:_____ Completed by:____________________ Relationship to Patient:______________

Date:________ Time:_____ Information reviewed by:____________________________________

Staff Documentation: Date:______________

Vital sign documentation:

BP:______________

Respirations:__________

Pulse:______________

Weight:______________

Date:____________ Time:_______ Staff Signature:____________________________________

MEDICAL RECORD