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New Patient Questionnaire

Name _____Date _____

Date of Birth _____Height? _____Weight ? ____ Social Security No._____

What is the reason you have come today? _____

How long have you known about it? _____

How did you find out about it? _____

Have you ever had cancer? _____ If so, what kind? _____

Has anyone in your family had breast cancer? _____ Ovarian cancer? _____

If so, who? _____

Have you ever had a breast biopsy? _____ If so, when? _____

What was found? _____

How old were you when you started to have periods? _____ Are your periods regular? _____

When was your last period? ___ Have you ever used birth control pills? ____ If so, when? _____

Have you been pregnant? ___ If so, how many times? _____

Have you had children? ___ If so, how many and how old were you? _____

Have you gone through menopause? ____ If so, when? _____

Have you had a hysterectomy? ___ If so, when? _____ Why? _____

Have you taken hormone therapy? ____ If so, what? _____

Is your general health good? ___ If not, why? _____

_____

Are you allergic to any medicines? ___ If so, what? _____

List any medicines you take: _____

_____

_____

Have you ever had surgery? ___ If so, what kind? _____
(Use an extra page if necessary.)