



Intake Questionnaire

We wish to ensure that our history and records are as complete and accurate as possible. Before you see the surgeon, please take a few minutes to fill out this intake questionnaire. We greatly appreciate your time.

Patient Name: _____ Date: _____

Allergies to Medication: _____

MEDICATION LIST: Please list any medications that you are currently taking.

Medication	Dosage	Frequency	Indication

PAST MEDICAL HISTORY: Please list your medical diagnosis.

Do you have now or have you ever had any of the following medical problems?

- | | |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Exposure |
| <input type="checkbox"/> Blood Clot or Embolus | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Abnormal Bleeding or Bruising | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Prior Blood Transfusion | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Heart Attack or Angina | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Irregular Heart rhythm or Palpitations | <input type="checkbox"/> Gallstones or Inflammation of Gallbladder |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Gastroesophageal Reflux Disease or Frequent heartburn |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hiatal Hernia or Paraesophageal Hernia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Peripheral Edema | <input type="checkbox"/> Other Bowel Disease: _____ |
| <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Emphysema or COPD | |

Problems list Cont'd:

- | | |
|------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Liver Problems or Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Enlarged Spleen | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Triglycerides |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Kidney or Bladder problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Arthritis, which joint? _____ |

For Patients being seen for a breast problem:

Age at Menarche (first period): _____ Do you still have regular periods? Yes No

If not, at what age did you go through menopause? _____

How many times have you been pregnant? _____ How many Children? _____

Did you breastfeed one or more of your children? Yes No How Long? _____

Are you currently on or have you ever been on oral contraceptive pills? Yes No

For how long? _____

Are you currently on or have you ever been on hormone replacement therapy (estrogen or progesterone)? Which one? _____ For how long? _____

Have you ever had a breast biopsy? Yes No

What was the pathology report? _____

Has anyone in your family had breast cancer, DCIS, or other breast pathology? Yes No

If so, how are they related to you and at what age was it diagnosed? _____

Have you ever had breast cancer, DCIS, or other breast pathology? Yes No

If so, at what age and what treatment did you receive? _____

PAST SURGICAL HISTORY: Please list the dates of all prior operations, the reason for the operation, the surgeon, and hospital name.

Operation	Reason	Date	Surgeon/Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Exercise Tolerance:

Can you walk from a distant parking space without stopping to rest? _____

Can you climb one flight of stairs without stopping to rest? _____

Can you climb two flights of stairs without stopping to rest? _____

If you stop to rest, is it because of chest pain, shortness of breath, joint pain, or other issues?

REVIEW OF SYSTEMS: Do you CURRENTLY have any of the following symptoms?

- | | |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Acid taste in your mouth or burning in your chest (heartburn) |
| <input type="checkbox"/> Weight loss (intentional or unintentional) | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Abdominal distension |
| <input type="checkbox"/> Yellowing of the skin (Jaundice) | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Excessive bleeding following minor cuts or dental surgery, easy bruising | <input type="checkbox"/> Black or tarry stools |
| <input type="checkbox"/> Problems with vision | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Yellowing of the sclera (whites of the eyes) | <input type="checkbox"/> Frequent or new constipation |
| <input type="checkbox"/> Swollen lymph nodes | <input type="checkbox"/> Change in caliber of stool (skinny stool) |
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Joint pains |
| <input type="checkbox"/> Blackouts or periods of dizziness | <input type="checkbox"/> Swelling of the legs |
| <input type="checkbox"/> Palpitations or irregular heartbeats | <input type="checkbox"/> Episodes of confusion |
| <input type="checkbox"/> Difficulty breathing or shortness of breath | <input type="checkbox"/> Temporary loss or blurring of vision |
| <input type="checkbox"/> Chronic cough or sputum (phlegm) production | <input type="checkbox"/> Temporary weakness of one or more limbs |
| <input type="checkbox"/> Blood in your sputum | <input type="checkbox"/> Facial weakness or numbness |
| <input type="checkbox"/> Difficulty or pain on swallowing | <input type="checkbox"/> Burning with urination or frequent urination |

FOR WOMEN: Breast mass? Nipple discharge? Changes in skin of the breast?
 Pregnancy?

SOCIAL HISTORY:

Occupation: _____

Marital Status: single married domestic partner widow(er) divorced

Do you live alone? Yes No If so, with whom do you live? _____

Children/Grandchildren? Ages? _____

Do you smoke? Yes No If so, how many pack(s)/day & for how long? _____

Have you smoked in the past? Yes No

If so, how many pack(s)/day & for how long? _____

When did you quit? _____

Do you drink alcohol? Yes No

If so, how many alcoholic beverages do you drink per week? _____

Do you or have you ever used IV drugs or other street drugs? _____

FAMILY MEDICAL HISTORY: Please list the major medical problems of all first and second degree relatives (including, but not limited to: cancer, heart disease, stroke, diabetes, and any other problems with anesthesia). Please be specific.

Cancers Type	Relative	Age at Diagnosis
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Diabetes	Type I or II	Relative	Age at Diagnosis
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Stroke or Heart Attack	Relative	Age at Diagnosis
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Other medical problems	Relative	Age at Diagnosis
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Problems with Anesthesia	Relative	Age at Diagnosis
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