Matthew J. Lynch, M.D.

Patient Health History Form Page 1 of 2

Today's Date________________

Name ________________________ Gender: Male/Female Age_______ Birth date________________

Type of Visit: ____New ____ Follow-up ____ Second Opinion ____ ER Follow-up (Date in ER) _______________

Have you seen any other physicians for this problem? _______ If so, name of doctor ______________________

Height ________ Weight ________ Recent loss _____lb. Recent gain _____lb. Current Bra Size _________

Past Medical History – Have you been diagnosed with and or treated for any of the following problems?

______ Breast Cancer Right Left Bilateral _____ Chemotherapy ______Radiation Therapy

______Heart ______ Lungs ______Liver ______Kidney
______Ulcers ______Poor Circulation ______Blood Pressure ______Diabetes
______Arthritis ______Psoriasis ______Cancer ______Seizures
______Stroke ______Infections ______Anemia ______Bleeding disorders
______Blood clots ______Psychiatric ______Hepatitis ______HIV/AIDS
______Thyroid Disease ______Asthma ______Depression ______SLE/Lupus

Name of Referring Physician _________________________________

Name & Address of Primary Physician _________________________
____
____

Last Mammogram (Date) ___________
Last Checkup (Date) _______________
Last Tetanus (Date) ________________

Previous Surgery
Operation Year Hospital/City Surgeon

____
____
____
____

Have you had any complications with surgery? _____ Yes _____ No If yes, please explain:

____

Medications – Name, Dosage and Frequency

____
____
____
____

Allergies ____ NO _____YES : Drug______________________________ Reaction: _____________________
Food ____________________________ Reaction: _____________________
Other ___________________________ Reaction: _____________________

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Patient Health History Form –

Patient Name ____

Social History

Alcohol _______ Heavy _____ Moderate _____Social _____ Occasional _____ None

Coffee ________ # cups per day Tea _____ # cups per day Soda ____ # bottles per day

Tobacco _____ Yes _____ No _____ pks/day x ________ years Quit (when) ________

Recreational Drug use _____ Yes _____ No Type ____________________

Has any member of your family reacted badly to being put to sleep for surgery?	_____ No _____Yes
Have you ever had a bad reaction to local anesthetic?	_____ No _____ Yes
Do you have an allergy to latex?	_____ No _____ Yes
Are you presently on birth control pills?	_____ No _____ Yes
Are you presently on hormonal replacement therapy?	_____ No _____ Yes
Have you ever taken Accutane for treatment of acne?	_____ No _____ Yes
Do you bleed or bruise easily (from cuts, surgery, tooth extractions, shaving)?	_____ No _____ Yes
Do you form large scars or keloids?	_____ No _____ Yes
Have you ever taken steroids, cortisone, or ACTH?	_____ No _____ Yes
Do you have shortness of breath with walking?	_____ No _____ Yes
Do you have or have you had any back troubles?	_____ No _____ Yes
Does your religion prohibit blood transfusions?	_____ No _____ Yes
Do you have or have you ever had any significant emotional problems?	_____ No _____ Yes
Have you ever had, or been advised to seek psychiatric care?	_____ No _____ Yes
Are you currently pregnant?	_____ No _____ Yes
Do you take Aspirin or Aspirin products (Ibuprofen, Motrin, Aleve, etc.)	_____ No _____ Yes