

DALLAS SURGICAL GROUP
Peter D. Beitsch, M.D., FACS

Name _____ Date _____

Problem you are here for:

Please answer *all* of the following questions to the best of your ability:

Age when first period started _____

Age when period stopped _____

Age when first child was born _____

of pregnancies _____ # of deliveries _____ Last menstrual period _____

Have you had a hysterectomy? _____ If yes, did they remove your ovaries? _____

Have you taken birth control pills? _____ If yes, from _____ to _____

Have you taken estrogen? _____ If yes, from _____ to _____

Have you had any prior breast biopsies? _____ If yes, Right Br _____ When _____

Left Br _____ When _____

Approximate Date of last Mammogram _____

Has anyone from your *mother's* side of the family had **breast cancer**? _____

If yes, who and at what age? _____

Has anyone from your *father's* side of the family had **breast cancer**? _____

If yes, who and at what age? _____

Has anyone from your *mother's* side of the family had **ovarian cancer**? _____

If yes, who and at what age? _____

Has anyone from your *father's* side of the family had **ovarian cancer**? _____

If yes, who and at what age? _____

Name of your Obstetrician/Gynecologist _____

Name of your Primary Care Doctor _____

Pharmacy Name _____

Address and/or Phone # _____

Initial _____

Name _____

PAST SURGERY (Operations)

Please list in chronological order. Check here if no prior surgery _____

Date	Operation	Hospital/Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

Have you ever had (check all that apply):

- | | | | |
|---|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other Heart Problems | <input type="checkbox"/> Organ Transplant | | |

MEDICATIONS

Please list all the medications you take. Include Aspirin and over the counter medications. Check here if none _____

Name	Dosage	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VITAMINS/HERBAL SUPPLEMENTS

Some vitamins and herbal supplements can cause increased bleeding during and after surgery. Please note if you take any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Fish Oil/Omega 3 | <input type="checkbox"/> Aspirin/Advil | <input type="checkbox"/> Ginkgo Biloba |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Ginseng | <input type="checkbox"/> Vitamin E |
| <input type="checkbox"/> Ephedra | <input type="checkbox"/> Echinacea | <input type="checkbox"/> St. John's Wort |
| <input type="checkbox"/> Valerian | <input type="checkbox"/> Kava | |

ALLERGIES

Please list all of your allergies. Check here if none _____

Substance	Effect
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Do you smoke? _____ How much? _____ For how long? _____
Do you drink? _____ How much? _____ For how long? _____

Initial _____

Name _____

REVIEW OF SYMPTOMS

Are you *currently* experiencing any of these symptoms (please check all that apply)?

Constitutional Symptoms

Fever Night Sweats Weight Loss

Eyes

Glaucoma Cataracts

Ear, Nose, Mouth and Throat

Ear Problems Sinus Problems Bleeding Gums
 Painful Swallowing Change in voice

Cardiovascular

High Blood Pressure Blood Clot in Legs Chest Pain
 Heart Attack Leg Pain when Walking Heart Murmur
 Irregular Heart Beats Congestive Heart Failure

Respiratory

Asthma Emphysema

Gastrointestinal

Difficulty Swallowing Peptic Ulcers Nausea/Vomiting
 Liver Disease Hepatitis

Genitourinary

Kidney Stones Kidney Infection
Men: Difficulty Urinating/enlarged prostate Women: Abnormal Bleeding

Musculoskeletal

Arthritis Osteoporosis

Skin

Psoriasis Skin Cancer Melanoma

Breast

Breast Lumps Nipple Discharge Breast Pain

Neurological

Headaches Stroke Seizures
 Migraines

Psychiatric

Depression

Endocrine

Diabetes Temperature Intolerance

Hematologic/Lymphatic

Anemia Blood Clotting Problem Daily Aspirin

Allergy/Immune System

Immune Deficiency Latex Allergy

Initial _____

Name _____

FAMILY HISTORY

Please include such items as:

Lung Cancer	Breast Cancer	Other Cancer	Heart Attack
Colon Cancer	Prostate Cancer	Kidney Disease	High Blood Pressure
Melanoma	Ovarian Cancer	Diabetes	Strokes

	<u>Living/Age</u>	<u>Deceased/Age</u>	<u>Medical Problems</u>
Parents:			
Father	_____	_____	_____
Mother	_____	_____	_____

Brothers:

Sisters:

Children:

PATIENT SIGNATURE _____ **DATE** _____

Initial _____