Mary A. Stanley, MD, FACS
Breast Surgery

New Patient Intake Form

Name_____ **DOB:** _____

Email address:_____

Referring Doctor:_____ **Primary Care Doctor:**_____

Other Doctors you would like information sent to:_____

Reason for Referral: _____

- ○ Mammo/Ultrasound _____
- ○ Breast Lump (location) _____
- ○ Pain _____
- ○ Nipple Discharge _____
- ○ Skin Changes _____
- ○ History of Breast Problems _____

_____

- ○ Prior Breast Biopsies _____

Mammogram date (xx/xx)_____ **Height** _____ **Weight**_____

Medical History:

_____

_____

Surgical History:

_____

_____

Social History:

- ○ Alcohol_____
- ○ Smoking _____
- ○ Living Status_____
- ○ Occupation_____

Medication (prescription and over the counter):

- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

Allergies: **Reaction:**

- ○ _____ _____
- ○ _____ _____
- ○ _____ _____

Review of Systems:

- ○ General (fever/chills)_____
- ○ Visual problems (eyesight changes, discharge)_____
- ○ Ear/Nose/Throat (earache, hearing loss, nasal discharge, sore throat)_____
- ○ Cardiovascular (chest pain, palpitations)_____
- ○ Respiratory (shortness of breath, wheezing, cough)_____
- ○ Gastrointestinal (abdominal pain, vomiting, diarrhea)_____
- ○ Genitourinary (dysuria, unexplained vaginal bleeding, vaginal dryness)_____
- ○ Musculoskeletal (bony pain, joint pain, limb swelling)_____
- ○ Integumentary (skin lesions, breast lump, rash)_____
- ○ Neurological (dizziness, fainting, headache)_____
- ○ Psychiatric (anxiety, depression)_____
- ○ Endocrine (hot flashes, muscle weakness)_____
- ○ Hematologic/Lymphatic (tendency for easy bleeding/bruising, swollen glands)_____
- ○ Sexual Concerns_____
- ○ Pain (location, duration and rate severity on a scale of 1-10)_____
- ○ Other_____

Family History (Cancer and age at diagnosis):

- ○ No cancer
- ○ Daughter _____
- ○ Son _____
- ○ Sister _____
- ○ Sister _____
- ○ Brother _____
- ○ Brother _____
- ○ Mother _____
- ○ Father _____
- ○ M Aunt _____
- ○ M Uncle _____
- ○ P Aunt_____
- ○ P Uncle _____
- ○ MGM _____
- ○ MGF _____
- ○ PGM _____
- ○ PGF _____

Gyn History:

- ○ Number of pregnancies _____
- ○ Number of deliveries _____
- ○ Age of 1st period _____
- ○ Age of 1st delivery _____
- ○ Birth Control Pill use (yrs) _____
- ○ Hormone Replacement use (yrs)_____
- ○ Tamoxifen/Raloxifene (Evista)_____
- ○ Uterus intact (y/n)_____
- ○ Ovaries intact (y/n)_____
- ○ Age at menopause_____
- ○ Last Menstrual period_____

Other Significant Family History:

- ○ _____
- ○ _____

Advance Directives: Do you have one on file? Yes ⬭ No ⬭

Would you like a written summary of the data you provided today? Yes ⬭ No ⬭

Would you like access to your health record online? Yes ⬭ No ⬭