

ELLE CENTER FOR BREAST HEALTH
LORI CHAPLESKIE, DO

PATIENT MEDICAL HISTORY

Patient's Name: _____ **Date of Birth:** _____

Although we specialize in treating disorders of the breast, we care about the total you. Health problems that you may have, or medications you may be taking may have an important interrelationship with the treatment you receive. Thank you for taking the time to complete this form.

	YES	NO
ARE YOU IN GOOD HEALTH?	△	△

HAVE THERE BEEN ANY CHANGES TO YOUR HEALTH DURING THE PAST YEAR?	△	△
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DATE OF YOUR LAST PHYSICAL EXAM: _____

PHYSICIAN'S NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	△	△
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HAVE YOU EVER BEEN HOSPITALIZED FOR A SURGICAL OPERATION OR SERIOUS ILLNESS?	△	△
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Please explain _____

ARE YOU TAKING ANY MEDICINE(S), INCLUDING NONPRESCRIPTION MEDICINE?	△	△
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If yes, which medicines? _____

DO YOU BRUISE EASILY?	△	△
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HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	△	△
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HAVE YOU HAD RECENT WEIGHT LOSS?	△	△
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HAVE YOU EVER TAKEN PHEN-FEN OR REDUX?	△	△
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DO YOU USE TOBACCO?	△	△
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DO YOU NOW OR HAVE YOU EVER USED CONTROLLED SUBSTANCES?	△	△
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ARE YOU WEARING CONTACT LENSES?	△	△
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DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU FEEL I SHOULD KNOW ABOUT?	△	△
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FOR WOMEN ONLY

ARE YOU OR DO YOU THINK YOU MAY BE PREGNANT?	△	△
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ARE YOU NURSING?	△	△
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ARE YOU TAKING BIRTH CONTROL PILLS?	△	△
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HAVE YOU HAD ANY ABNORMAL BLEEDING?	△	△
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	<u>YES</u>	<u>NO</u>
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
Local anesthetics like novocaine?	△	△
Penicillin or other antibiotics?	△	△
Sulfa drugs?	△	△
Sedatives or sleeping pills?	△	△
Aspirin?	△	△
Iodine?	△	△
Any metals?(i.e. nickel, mercury)	△	△
Latex or rubber?	△	△
Other? (please list) _____	△	△

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?		
Rheumatic fever/heart disease?	△	△
Scarlet fever?	△	△
Heart defect or murmur?	△	△
Heart trouble, attack or angina?	△	△
Chest pain?	△	△
Shortness of breath?	△	△
Pacemaker?	△	△
Heart surgery?	△	△
High or low blood pressure?	△	△
Congenital heart problem?	△	△
Swelling of feet, ankles or hands?	△	△
Hepatitis, jaundice or liver disease?	△	△
Stroke?	△	△
Sinus trouble?	△	△
Lung/breathing problems?	△	△
Asthma or hay fever?	△	△
Hives or skin rashes?	△	△
Fainting or dizzy spells?	△	△
Diabetes?	△	△
AIDS or HIV infection?	△	△
Thyroid problems?	△	△
Allergies?	△	△

continued on other side

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LORI CHAPLESKIE, DO

	<u>YES</u>	<u>NO</u>
Arthritis or rheumatism?	△	△
Joint replacement/implant?	△	△
Stomach ulcer?	△	△
Kidney trouble?	△	△
Tuberculosis?	△	△
Persistent cough?	△	△
Coughing up blood?	△	△
Chemotherapy?	△	△
Sexually transmitted disease?	△	△
Epilepsy or seizures?	△	△
Anemia?	△	△
Glaucoma?	△	△
Nervousness or anxiety?	△	△
Tonsillitis?	△	△
Tumors?	△	△
Mental health care?	△	△
Neck, back or spine problems?	△	△
Chemical dependency?	△	△
Mitral valve prolapse?	△	△
Cortisone treatment?	△	△
Cold sores/fever blisters?	△	△
Hypoglycemia?	△	△
Eating disorders?	△	△