ASHIKARI
BREAST CENTER

Date: _____ Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: ☐ Unemployed ☐ Retired ☐ Employer: _____

Business Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Emergency Contact**: Name: _____

Relationship: _____ Phone Number: _____

How did you find us? _____

**Referring Doctor**: _____ Phone Number: _____

Address: _____

**Primary Insurance Carrier**: _____

Name of Insured: _____

Date of Birth: _____ Social Security Number: _____

Policy Number: _____

**Secondary Insurance Carrier**: _____

Name of Insured: _____

Date of Birth: _____ Social Security Number: _____

Policy Number: _____

**Preferred Pharmacy** Name: _____

Address: _____

Phone number: _____

ASHIKARI
BREAST CENTER

Name: Date of Birth:

**Please circle any symptoms that may apply to you:**

| | |
|---|---|
| **Constitutional** | Appetite Chills Malaise Fever Fatigue Insomnia Energy |
| **Skin** | Itching Rash Hives Ulcers Jaundice Lesions |
| **Head/Neck** | Hearing Nose Bleeds Ringing in Ears Allergies Pain Dizziness Mouth Sores Bleeding Gums |
| **Eyes** | Blurred Vision Diminished Vision Discharge Pain Redness Blindness |
| **Respiratory** | Shortness of Breath Wheezing Cough |
| **Cardiovascular** | Chest Pain Fainting Sleeping Upright Swelling Palpitations |
| **Gastrointestinal** | Indigestion Diarrhea Nausea Constipation Abdominal Pain Bloating Blood in Stool Blood in Vomit |
| **Genitourinary** | Urgency Blood in Urine Burning Rash Flank Pain<br>Male: Difficulty with Erection Testicular Pain Discharge<br>Female: Discharge Painful Periods Irregular Periods Pelvic Pain |
| **Endocrine** | Steroid Use Breast Enlargement Excess Thirst Excess Urination Weight Gain |
| **Musculoskeletal** | Joint Pain Muscle Pain Neck Pain Back Pain Difficulty Walking |
| **Neurological** | Fainting Seizures Memory Loss Sensory Loss Weakness Altered Speech Altered Mental Status |
| **Psychiatric** | Anxious Stressed Depression Delusions Mood Swings Hallucinations |
| **Heme/Lymph** | Fine Red Spots Nails/Skin Bleeding Bruising Swollen Glands Paleness |
| **Other** | |

**Social History:** Smoking: ☐ Never ☐ Quit: ☐ Smokes: pk/day x years

Alcohol: ☐ Never ☐ Social ☐ Drinks/Week

**Height:** **Weight:**

**Race/Ethnicity:** ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other

**Number of Children:** **Number of Miscarriages:** **/Abortions:**

Your Age With First Born Child:

Age of First Period: Last Period: ☐ Menopause-How Old?

Have You Ever Been on Hormone Replacement? ☐ No ☐ Yes-How Long?

ASHIKARI
BREAST CENTER

Name: Date of Birth:

**Past Medical History:** _____

_____

**Allergies**: ☐ None

## Current Medications

| Name | Dosage | How Often | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Surgical/Hospitalization History

| **Year** | **Type** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Have you ever had a breast biopsy before?** ☐ **No** ☐ **Yes**

ASHIKARI
BREAST CENTER

Name: Date of Birth:

**Have you ever had any genetic testing done?** ☐ No ☐ Yes

## Family History of Cancer/Disease

Please fill in information on family history of **ANY** cancers; including **breast, ovarian, uterine, endometrial, colon, pancreatic, prostate, melanoma, stomach, bladder, brain, thyroid, leukemia**, and/or **lymphoma**. This is help us see if you qualify for genetic testing.

| **Relative** | Maternal | Paternal | **Location/Type** | **Age of Diagnosis** | Alive | Deceased |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |