Breast Care Center
Upstate University Hospital-Community Campus
4900 Broad Rd
Syracuse, NY 13215

Dr. Kristine Keeney
Dr. Mary Ellen Greco
(315) 492-5660

Patient Information

Patient Name: _____
DOB: ___/____/_____ Age: _____ Height: _____Weight:_____
Social Security # ___/__/____ Phone: (Home) (___) _____-_____
(Work)(___)_____-_____ (ext.) _____ (Cell) (___) _____-_____
Address: _____
What are your concerns for Today's Visit?
_____
_____

Referring Physician Information

Referring Physician (Name, Address, Phone)
_____
_____
_____
Primary Care Physician (Name, Address, Phone)
_____
_____
_____

Patient Medical History

(PLEASE CHECK THE APPROPRIATE BOX IF YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING)

	YOU	FAMILY	CONDITION
Anesthesia problems			
Bleeding problems			
Birth defects			
Diabetes			
High Blood Pressure			
Thyroid problems			
Tuberculosis			
Heart Disease			
Respiratory problems			
Stomach or Intestinal Problems			
Vision problems			
Kidney Disorder			
Neurological problems			
Psychological problems			
Cancer			
Other Medical diagnosis			

Screenings

Date of Last Colonoscopy

___/_____/___

_____

Date of Hospitalizations/Surgeries

_____
_____
_____
_____
_____
_____
_____
_____
_____

List any street drugs you use:
_____
_____
What is your Occupation?
_____
Married? Y/N

Social History

	Yes	No	Comment		Yes	No	Comment
Do you smoke: If so how much?				Do you drink alcohol?			
If no, did you ever smoke?				If so, how much do you drink?			
Are you in an abusive relationship?							

Family History

		Age	Health Status			Cause of Death
			Good	Poor	Deceased	
	Spouse					
	Father					
	Mother					
Siblings (circle)	Brother/Sister					
	Brother/Sister					
	Brother/Sister					
Children (circle)	Daughter/Son					
	Daughter/Son					
	Daughter/Son					

PATIENT NAME: _____ DOB: _____

MEN:

Are you sexually active? (circle)	Yes	No	Difficultly having or maintaining an erection? (circle)	Yes	No	Known prostate problems? (circle)	Yes	No

WOMEN:

Are you sexually active? (circle)	Yes	No	Last mammogram?		
Age at birth of 1st child			Results?		
Number of pregnancies			Age when menstrual period began?		
Number of children			Irregular Periods?	Yes	No
Did you breast feed? (circle)	Yes	No	Painful Cramps w/ periods? (circle)	Yes	No
Last pap smear?			Menopause (age)		
Results?			Lumps in breasts?	Yes	No
			# Past breast biopsies?		
			Results?	Cancerous / Pre-Cancerous / Negative	

Who do you see for your yearly breast exams?

_____

_____

Do you take or have you ever taken:

Female hormone replacement?	Yes	No
Birth Control	Yes	No
Norplant?	Yes	No

Are you of Ashkenazi Jewish descent?	Yes	No
Have you or anyone in your family been genetically tested?	Yes	No
Who?		
Results?		

Do you have a family history (siblings, mother's, father's, family of:

Breast Cancer?	Yes	No	Who?	Age at diagnosis:
Ovarian Cancer?	Yes	No	Who?	Age at diagnosis:
Colon Cancer?	Yes	No	Who?	Age at diagnosis:

PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY HAVING:

BREAST ISSUES	GENERAL	MUSCULO/SKELETAL
Breast implants; saline or silicone	Chills	Joint aches
Discharge	Daytime sleepiness	Trouble walking
Pain	Fatigue	
Rash	Fever	NEURO
	Night sweats	Headache
EAR, NOSE AND THROAT	Weight loss or gain	Passing out
Dizziness		
Ear noises	GENITO-URINARY	PSYCHIATRIC
Hearing loss	Bloody or dark brown urine	Depression
Nasal congestion	Difficulty completely emptying bladder	Mental health problems
Problem snoring, apnea	Difficulty starting urination	
Sense of smell	Frequent urination	RESPIRATORY/CARDIAC
Sinus pressure or pain	Loss of bladder control	Chest pain
Speech or voice	Painful urination	Cough
Throat dryness/itching	Waking up at night to urinate	Coughing up blood
Throat pain		Palpitations
		Shortness of breath
GASTROINTESTINAL	ENDOCRINE	Wheezing
Constipation	Feeling colder than others	
Dark, tarry or bloody stools	Feeling warmer than others	SKIN
Diarrhea		Growing / changing mole
Difficulty swallowing	HEMATOLOGIC / LYMPHATIC	Hives
Heartburn	Bleeding	Itching
Loss of bowel control	Easy bruising	Lumps under skin
Nausea or vomiting	Swollen glands	Rash
		Skin or hair changes

PATIENT NAME: _____ DOB: _____

Pharmacy Name:	Phone Number:

MEDICATIONS

Are you currently taking a blood thinner? (Circle)	No	Yes – if so, what type? _____

LIST OF MEDICATIONS YOU ARE TAKING, INCLUDING OVER THE COUNTER MEDICATIONS, VITAMINS AND MEDICATIONS TAKEN "AS NEEDED"

NAME OF MEDICATION	DOSE	FREQUENCY TAKEN	REASON FOR TAKING

ALLERGIES

LIST ALL MEDICATION ALLERGIES AND REACTIONS

NAME OF MEDICATION	REACTION

OTHER

☐ Please check here if for religious reasons, you will not take blood products.

Signature: _____ Date: _____