# Breast Surgery Center of North Texas

Dr. Radha Iyengar

**Name**: _____ **Primary Care Physician:** _____

**Reason for visit:** _____ **Referring physician:** _____

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**Drug Allergies** ☐ **No** ☐ **Yes (**If yes, please list all known drug allergies and reactions)

_____ _____

_____ _____

_____ _____

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**Current Medications and Dosages:** (use back of page if more space needed)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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**Surgical History**: (Please list all surgeries and year it was done)

_____ _____

_____ _____

_____ _____

_____ _____

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**Family History:** (Please list any and all family members with chronic medical problems)

_____ _____

_____ _____

_____ _____

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**Do you currently smoke? Yes** ☐ **No** ☐ If yes, check all that apply: ☐ cigarettes ☐ cigars ☐ pipe

**Are you a former smoker? Yes** ☐ **No** ☐

If yes: Date quit? _____ How many total years? _____ How many packs/day? _____

**Have you ever used smokeless tobacco? Yes** ☐ **No** ☐

If yes, please specify: _____

**Do you drink alcohol? Yes** ☐ **No** ☐

If yes: How many drinks/day on average? _____ How many days/week? _____

**Do you use recreational drugs? Yes** ☐ **No** ☐

If yes, please specify: _____

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**Name: _____**

**Last menstrual period (if applicable):_____**

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**Have you ever been diagnosed with breast cancer?** Yes ☐ No ☐

If yes, please specify_____

**Are you of known Ashkenazi/Eastern European Jewish ancestry?** Yes ☐ No ☐

If yes, please specify_____

**Age at first period**? _____

**Age at menopause (if applicable)?** ____

**How many pregnancies have you had?** _____

**How many live births have you had?** _____

**Your age at first child's birth?** _____

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

If yes, how many? _____

Did any of these show atypical cells? Yes ☐ No ☐ If yes, please specify_____

**Current or prior birth control use?** Yes ☐ No ☐ If yes, total number of years used? _____

**Current or prior hormone related therapy?** Yes ☐ No ☐ If yes, total number of years used? _____

**Have you ever had radiation therapy to the chest or breast?** Yes ☐ No ☐

If yes, please specify_____

**Do you have <u>family history</u> of breast cancer?** Yes ☐ No ☐

If yes, please list relation to you and age at diagnosis: _____

_____

**Do you have <u>family history</u> of ovarian cancer?** Yes ☐ No ☐

If yes, please list relation to you and age at diagnosis: _____

_____

**When was your last mammogram**? (Month/year)_____Location:_____