UAB MEDICINE

THE KIRKLIN CLINIC OF UAB HOSPITAL

(FOR DICTATION PURPOSES ONLY)

General Information

Name: _____

Primary Care Physician (or MD to whom you would like records sent): _____

MD Phone: _____ Location _____

Childbirth History

Age at first live birth? _____ Number of pregnancies? _____ Number of live births? _____

Did you breast feed? ☐ N ☐ Y Longest breast feeding duration: _____ months

Menstrual History

Menopausal status: pre ☐ peri ☐ post ☐ unknown ☐ Age at first period? _____ Age at menopause? _____

Ovaries removed? One ☐ Both ☐ No ☐ Age removed? _____ Uterus removed? ☐ N ☐ Y

Last menstrual period date? _____

Hormone Replacement Therapy

Have you ever taken hormone replacement therapy? Please circle. No, never/Yes, currently/Yes in the past/Unknown

If yes, circle: Estrogen Alone / Combined Estrogen and Progesterone/ Unknown/ Other _____

How many years taken? _____ Intended duration? _____ Years since taken? _____

Have you ever taken Tamoxifen? ☐ N ☐ Y Evista? ☐ N ☐ Y Femara? ☐ N ☐ Y
Arimidex? ☐ N ☐ Y Aromasin? ☐ N ☐ Y

Biopsies

Have you had a breast biopsy? ☐ N ☐ Y How many? _____ If so, please list date, facility and result:

_____

Have you had **any** breast surgical procedure in the operating room (biopsy, cyst aspiration, lumpectomy, mastectomy, reduction, implants, breast lift, etc.? ☐ N ☐ Y If so, please list date(s), result(s), and indicate if silicone or saline implants:

Date(s)	Result(s)	Facility	Procedure

Family History

Are you of Ashkenazi Jewish descent? ☐ N ☐ Y ☐ Unknown

Breast History

Have you been diagnosed with breast cancer? ☐ N ☐ Y

If yes, when? _____ Which breast? _____

(FOR DICTATION PURPOSES ONLY)

Have you ever had chemotherapy or radiation therapy for ANY condition? _____

"Medical Problems"

Any history of blood clots? ☐ N ☐ Y Any previous difficulty with anesthesia? ☐ N ☐ Y

Date:	Illness(es):

Date:	Surgeries:

Review of Systems

Comments: _____

Do you currently or have you had any of the problems below within the past 3 months?

General:	☐ Fever	☐ Weight Loss	☐ Weakness	☐ Fatigue	☐ Chills
Eye:	☐ Vision Changes	☐ Pain	☐Drainage		
Ear, Nose, Throat:	☐ Hearing Changes	☐ Nasal Congestion	☐ Sore Throat	☐ Trouble with Balance	☐ Ear pain
Respiratory:	☐ Shortness of Breath	☐ Cough	☐ Wheezing	☐ Phlegm	
Cardiovascular:	☐ Palpitations	☐ Leg Swelling	☐ Fainting	☐ Chest Pain	
Breast:	☐ Lump/Mass	☐ Discharge	☐ Redness	☐ Pain	
Gastrointestinal:	☐ Nausea	☐ Vomiting	☐Diarrhea	☐ Constipation	☐Heartburn
Genitourinary:	☐ Painful Urination	☐ Blood in Urine	☐Difficulty Urinating	☐ Sexual Difficulties	☐ Change in urine stream
Lymph:	☐ Bruising	☐ Easy Bleeding	☐ Swollen Lymph Glands		
Musculoskeletal:	☐ Back Pain	☐ Joint Pain	☐ Muscle Pain	☐ Stiffness	
Skin:	☐ Rash	☐ Itching	☐ New Moles	☐ Color Changes	☐ Lesions
Neuro:	☐ Headache	☐ Fainting	☐ Numbness/Tingling	☐ Memory Loss	
Psychiatric:	☐ Depression	☐ Anxiety	☐ Suicidal	☐ Hallucinations	
Endocrine	☐ Hormones problems	☐ Thyroid Disease	☐ Diabetes	☐ Heat or Cold Intolerance	

Please be prepared to list the medication that you are currently taking. You may attach a list desired.