

Patient Name: _____

Medical History

Reason for Visit:

- New Breast Cancer Breast Reconstruction. Benign Breast Disease
 Cosmetic Consultation for _____ Abnormal skin lesion
 Other _____

Medication Allergies:

Current Medications:

Medical History

- Breast Cancer Lung problems (COPD/asthma/pulmonary edema)
 Chemotherapy history Heart problems (Heart attack, Hypertension, cardiac stents)
 Radiation history Diabetes Kidney Disease
 Other: _____
 Last Menstrual Cycle _____

Previous surgeries & year

Implants & sizes: _____

Do you Smoke Tobacco or Marijuana: yes no

How many alcoholic beverages a week: _____

Any Drug use previously: yes no

Family History of Cancer (relation/age at diagnosis/type of cancer)

