Gerrish Breast Care Center
Anna Jaques Hospital

One Wallace Bashaw Jr Way, Suite 2002
Newburyport MA 01950
Tel: 978-463-8686 • Fax: 978-499-8513

Peter A. Hartmann M.D., F.A.C.S., Medical Director

Name:_____ Date:_____

Date of Birth:_____Sex: _____ F_____M Marital Status:_____

Race:_____ Preferred language _____ Nationality_____

Address:_____
Street City State Zip Code

Primary Telephone_____Secondary Telephone_____

Can messages be left at your Primary No#? Yes _____No _____ On your cell phone? Yes _____No _____

Social Security No:_____

Primary Care Physician _____ Referred by:_____

Primary Insurance:_____ Subscriber:_____

Secondary Insurance:_____ Subscriber:_____

Employer:_____ Occupation:_____

Employer Address:_____

Work Phone Number:_____

Emergency Contact: _____ Relationship:_____

Emergency Contact Phone Number: _____

Pharmacy: _____
Street City State Zip Code

Do you have any allergies to medication, food or other? Yes_____ No_____

Allergy:_____Reaction_____

Allergy:_____Reaction_____

Allergy:_____ Reaction_____

In your own words, please tell us the reason for your visit today?

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

Do you take aspirin every day? Yes_____No_____

PAST MEDICAL HISTORY

Do you have a history of any of these disorders?

	Yes	No		Yes	No
Alcoholism	____	____	High Blood Pressure	____	____
Anemia	____	____	Kidney Disease/Stones	____	____
Arthritis	____	____	Liver Disease	____	____
Bleeding disorder	____	____	Lung Disease/COPD	____	____
Blood Clots	____	____	Mental Illness	____	____
Blood Transfusion	____	____	Migraines	____	____
Depression/Anxiety	____	____	Osteoporosis	____	____
Diabetes	____	____	Pneumonia	____	____
Drug Abuse	____	____	Seizures	____	____
Glaucoma	____	____	Stroke	____	____
Heart disease	____	____	Thyroid Disease	____	____
Hepatitis A B C	____	____	Ulcers/Reflux	____	____
High Cholesterol	____	____	Other_____		
Cancer	____	____	_____		

LIST ANY/ALL PAST SURGICAL PROCEDURES

Colonoscopy Yes_____No_____

_____

_____

_____

FAMILY HISTORY

Please list the relationship and age at diagnosis of family members who have had any of the following cancers? (i.e. Mother, age 68)

	Siblings/Children	Mother's side	Father's side
Breast Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Colon/Rectal Cancer	_____	_____	_____
Uterine Cancer	_____	_____	_____

Are you of Askenazi Jewish Descent? Yes_____No_____

GYNECOLOGIC/BREAST HISTORY

When was your most recent mammogram? _____

Age at first menstrual period _____ Last menstrual period _____

Number of: pregnancies_____ Live births_____

Miscarriage/ectopic pregnancy/abortion? Yes_____No_____

Age at time of first live birth _____

Did you nurse your children? Yes_____No_____

Birth Control Pill use: Age_____ Duration_____

Hormone Replacement Therapy: Age_____ Duration_____

DES exposure Yes_____ No_____

Do you perform breast self exam? Yes_____ No_____

Do you feel breast pain or tenderness? Yes_____ No_____

Do you experience breast swelling? Yes_____ No_____

Have you noticed a breast lump or mass? Yes_____ No_____

Do you experience nipple discharge? Yes_____ No_____

Have you ever had a breast cyst drained? Yes_____ No_____

Have you ever had a breast biopsy? Yes_____ No_____

Smoking: Have you ever been a smoker? Yes_____ No_____

Do you currently smoke? Yes_____ No_____

How many cigarettes each day?_____

Alcohol: How many drinks in a typical week? _____

Caffeine: How many cups coffee/tea/soda each day?_____

Exercise: How many days do you exercise each week? _____

Please list if you are having any of the following symptoms.

	Yes	No
General		
Weight loss	_____	_____
Weight gain	_____	_____
Appetite loss	_____	_____
Fever	_____	_____
Fatigue	_____	_____
Hemotology		
Bleeding/Clotting Disorder	_____	_____
Anemia	_____	_____
Skin		
Rash	_____	_____
Bruising	_____	_____
Eyes		
Vision changes	_____	_____
Ears		
Hearing loss	_____	____
Respiratory		
Short of breath	_____	_____
Hoarseness	_____	_____

	Yes	No
Heart		
Chest pain	_____	_____
Palpitations	_____	_____
Gastrointestinal		
Difficulty Swallowing	_____	_____
Change in Bowel habit	_____	_____
Blood in stool	_____	_____
Urinary		
Incontinence	_____	_____
Blood in urine	_____	_____
Painful/Difficult urination	_____	_____
Musculoskeletal		
Joint pain	_____	_____
Past Fracture	_____	_____
Neurologic		
Headache	_____	_____
Seizures	_____	_____
Anxiety/Depression	_____	_____