Advanced Surgical Care
of Northern Illinois, Ltd.

802 Fox Glen Court
Barrington, Illinois 60010

_____ _____
Name *Date*

Women's Health History

This questionnaire is designed to help us obtain a complete patient history and identify any problem area which will assist the doctor in making a diagnosis. Your cooperation is greatly appreciated.

Name:_____ Birth Date:_____ Age:_____

1. Any previous x-ray examination of the breast? Yes/No If so, where, when, and results, if known?
_____

2. At what age did you begin menstruation?_____ Stop menstruation?_____

3. What was the date of your last menstrual period?_____

4. Do you have any children? Yes/No How many?_____ Age at first pregnancy?_____

5. Were your children breast fed? Yes/No Currently?_____

6. Have you ever had any of the following on either breast?

	Yes	No	Right	Left	Now
Discharge					
Pain					
Mastectomy					
Biopsy					
Enlargement					
Surgery					
Injections					
Lump					

7. Is there a history of breast cancer in your family?_____ Whom?_____
What age at diagnosis?_____

8. Are you taking any medications?_____

9. Coffee, tea, cola drinks of chocolate usage per day:_____
_____

10. Other complaints:_____

For the doctor's use:

Med Hx:_____ Allergies:_____
Surg Hx:_____ Tobacco:_____
Meds:_____ ETOH:_____
Recreational Drugs:_____