Susan A. Seedman, M.D., F.A.C.S., P.C.
Sylvia M. Ramos M.D., M.S., F.A. C.S.
Edna Lopez, CFNP

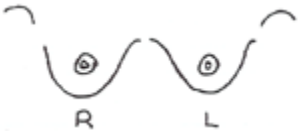
Initial Evaluation Type: ❑ New Patient ❑ Consultation ❑ Second Opinion

Patient's Name: _____ Date of Birth: ___/___/___ SS# _____

Primary Physician: _____ Date Today: _____

Reason for Visit: (Draw area on the diagram)

_____
_____
_____
_____



PERSONAL MEDICAL HISTORY (Check/fill in all that apply to any medical problems you have or have had in the following body areas.)

General Problems

	NOW	PAST
❑ Constitutional (fever, weight loss, etc.) _____	❑	❑
❑ Eyes/Vision _____	❑	❑
❑ Ears, nose & throat, mouth _____	❑	❑
❑ Heart/blood pressure _____	❑	❑
❑ Lungs _____	❑	❑
❑ Gastrointestinal _____	❑	❑
❑ Kidney _____	❑	❑
❑ Musculoskeletal _____	❑	❑
❑ Neurological _____	❑	❑
❑ Blood/lymph _____	❑	❑
❑ Endocrine – diabetes/thyroid _____	❑	❑
❑ Genitourinary _____	❑	❑
❑ Psychiatric _____	❑	❑
❑ Cancer (type, date) _____	❑	❑
❑ Other _____	❑	❑

❑ Surgery/operations (list and give dates) _____
_____

❑ Medications (present) _____
_____

❑ Allergies _____

Breast/Gynecological Problems

	NOW	PAST
❑ Breast pain _____	❑	❑
❑ Breast lump _____	❑	❑
❑ Breast cyst _____	❑	❑
❑ Nipple discharge _____	❑	❑
❑ Breast trauma _____	❑	❑
❑ Cyst aspiration _____	❑	❑
❑ Breast biopsy _____	❑	❑
❑ Breast cancer _____	❑	❑
❑ Post menopausal symptoms _____	❑	❑
❑ Hormone use _____	❑	❑
❑ Birth control pills _____	❑	❑
❑ Abnormal pelvic exam _____	❑	❑

❑ Ovarian cysts _____	❑	❑
❑ Number of pregnancies _____		
❑ Age at first childbirth _____		
❑ Number of children _____		
❑ Date of last pelvic exam _____		
❑ Last mammogram date _____		
❑ Breast self-examination _____		
❑ Age at 1st period _____		
❑ Date of last period _____		
❑ Gynecological surgery _____		
_____		
_____		

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Patient's Name: _____ Date of Birth: ___/___/___ SS# _____

Primary Physician: _____ Date Today: _____

SOCIAL HISTORY

❑ Occupation/employment _____
❑ Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Other
❑ Tobacco/nicotine use ❑ Now ❑ Past _____
❑ Alcohol use ❑ Now ❑ Past _____
❑ Drug abuse ❑ Now ❑ Past _____

FAMILY MEDICAL HISTORY (indicate any medical problems, conditions or medicine use for any blood relative, male or female, close or distant. Please check and describe all that apply.)

❑ High blood pressure _____
❑ Heart disease/attacks _____
❑ Lung _____
❑ Kidney _____
❑ Diabetes _____
❑ Thyroid _____
❑ Allergy to anesthesia _____
❑ Other _____
_____
_____

❑ Cancer _____
❑ Breast _____
❑ Ovary _____
❑ Uterus _____
❑ Colon _____
❑ Prostate _____
❑ Brain _____
❑ Lymphoma _____
❑ Leukemia _____
❑ Other _____

NURSE'S NOTE:

_____
_____
_____
_____

HT _____ WT _____ BP _____ HR _____ RR _____ TEMP _____

CHIEF COMPLAINT:

_____
_____
_____
_____
_____
_____

HPI: Location _____
Quality _____
Severity _____
Duration _____
Timing _____
Context _____
Modifying factors _____
Associated symptoms _____