WILDFLOWER
BREAST CENTER

New Patient Intake Form

Patient Name: ___________________________________ MRN: _____________________ Date: ______________

DOB: ________________________ Age: ____________ Sex: ☐ Male ☐ Female Pronouns: ______________

Primary Care Physician: ________________________________ Surgeon: _________________________________

Specialists/ Other Physician (s): ____

Medical History		
Major Medical Problems (i.e., Diabetes, Heart Problems, etc.)	**Surgeries** (Please list approximate dates)	**Hospitalizations** (Please list appropriate dates)

Drug Allergies: ☐ **Yes** ☐**No**
Please List:

Pacemaker: ☐ **Yes** ☐**No**

Current Medications		
Medication	**Dose**	**Frequency**

Most Recent Vaccinations	
Type	Date
COVID-19 1st dose: 2nd dose: Booster:	
Flu Shot	

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Prior Cancer History
Have you had past experience with cancer? ☐ No ☐ Yes, type of cancer: ____________________ When were you diagnosed? ______________
Have you had any prior radiation treatment? ☐ No ☐Yes, in year(s) _________________________ Where? _______________________________
Have you had any prior chemotherapy treatment? ☐ No ☐Yes, in year(s) _________________________ Where? _______________________________

Women's Health
Age at first period: __________________
Age at birth of first child: ______________
Did you breastfeed?
Age at Menopause? _________________
Have you ever used Hormone Replacement Therapy? ☐No ☐ Yes, _______________
Nipple Discharge? ☐No ☐ Yes, started? _________
Breast Mass/ Lump? ☐ No ☐ Yes

Social History
Employment: ☐ No ☐ Yes ☐ Retired Occupation: ____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: ____
Number of people in household:
Are you religious? ☐ No ☐ Yes In case of emergency, do you accept blood transfusion (s)? ☐ No ☐ Yes
Do you now or have you ever smoked? ☐ No ☐ Yes, I started at age____, quit at age ______. Cigarettes, _________ per day. Other tobacco, _________ per day.
Do you drink alcohol? ☐ No ☐ Yes
Have you ever been treated for drugs and alcohol? ☐ No ☐ Yes
Have you been exposed to hazardous materials? ☐ No ☐ Yes

Family History	
Is there a history of cancer in your family? ☐ No ☐ Yes, please list below:	

Most Recent Screening		
Type	Date	Results
Mammogram Abnormal?		
Breast MRI Abnormal?		
Breast Ultrasound Abnormal?		
Breast Biopsy Abnormal?		
Colonoscopy		

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Review of Systems

Patient Name: ________________________________ MRN: ____________________ Date: _____________

Eyes	**Y**	**N**
Glaucoma		
Cataracts		
Eye pain		
Double vision		
Floating lights		
Immunology	**Y**	**N**
Rheumatoid arthritis		
Lupus		
Scleroderma		
Gastrointestinal	**Y**	**N**
Chronic abdominal pain		
Persistent nausea/vomiting		
Heartburn		
Appetite loss		
Diarrhea		
Blood/clay-colored stool		
Hemorrhoids		
Constipation		
Hepatitis		
Gall bladder disease		
Difficulty swallowing		
Genitourinary	**Y**	**N**
Excessive Dribbling		
Burning upon urination		
Incontinence		
Frequent urination at night		
Blood in urine		
Kidney stones		
Reproductive- Male	**Y**	**N**
Discharge/sore penis		
Hernias		
Testicular pain or lumps		
History of venereal disease		
Sexually active		

Musculoskeletal	**Y**	**N**
Numbness in arms or legs		
Tingling in arms or legs		
Problems working		
Muscle jerking		
Paralysis		
Shaking/tremors		
Limited motions		
Muscle pain		
Psychiatric	**Y**	**N**
Depression		
Anxiety		
On psychiatric medicine?		
Ear/Nose/Throat	**Y**	**N**
Hearing loss		
Ringing in ears		
Pain in ear		
Discharge from ear		
Repeated nose bleeds		
Prolonged hoarseness		
Dry mouth		
Respiratory	**Y**	**N**
Chronic cough		
Difficulty breathing		
Asthma		
Emphysema		
Bronchitis		
Sit up to breathe easier?		
Wheezing		
Require oxygen? ____L/min		
Endocrine	**Y**	**N**
Hot/cold intolerance		
Excessive thirst/hunger		
Diabetes?		
If yes, do you take insulin?		

Neurological	**Y**	**N**
Dizziness/fainting		
Memory loss		
Seizures		
Speech changes		
Sensory loss or changes		
Weakness in arms or legs		
Cardiovascular	**Y**	**N**
High blood pressure		
Heart disease or defects		
Pacemaker		
Chest pain		
Hemo/Lymphatic	**Y**	**N**
Taking blood thinners		
Anemia		
Bruising/bleeding		
Swollen lymph nodes		
HIV positive		
If yes, diagnosis date:		
Night sweats		
Frequent infections		
Allergies	**Y**	**N**
Hay fever		
Molds		
Skin (non-breast)	**Y**	**N**
Lumps or bumps		
Color change in moles		
Hives or Rashes		
Psoriasis/eczema		
Prior skin cancer		
Shingles		

Patient signature: ____ Date: ____________________