GRIFFIN FACULTY PHYSICIANS
Denise Barajas MD, F.A.C.S

What brings you here today? _____

SURGICAL HISTORY

Procedure	Date

MEDICATION HISTORY

Medication	Dose & Frequency

ALLERGIES/ADVERSE REACTION

Medication/Drug/Food	Type of reaction
Any allergies to shellfish/eggs? Select:	

Family History

Do you have any of your 1st degree relatives that are of Ashkenazi descent? Select:

	AGE DIAGNOSED	ALIVE	DECEASED	UNKNOWN	HISTORY OF BREAST CANCER?	HISTORY OF OVARIAN CANCER?
Mother						
FATHER						
SIBLING						
SIBLING						
SIBLING						
GRANDMOTHER						
GRANDMOTHER						
GRANDFATHER						
GRANDFATHER						
AUNT						
OTHER						

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PAST MEDICAL HISTORY							
	YES	NO	NOTES		YES	NO	NOTES
Acid Reflux				Fibromyalgia			
Alcoholism/Substance Abuse				Glaucoma			
Anemia				Heart Attack			
Anxiety Disorder				Heart Disease			
Any blood relative who had anesthesia complications				High Blood Pressure			
Complications related to anesthesia				High Cholesterol			
Arrhythmia/Palpitations				Intestinal Problems-Ulcer,			
Arthritis				Jaundice or Liver Disease			
Asbestos Exposure				Kidney Disease or Problems			
Asthma or Allergies				Lung Disease (Pneumonia,			
Auto Immune Disease				Migraine Headaches			
Bladder Disease				Fainting Spells			
Bleeding Tendencies				Obesity			
Blood Clotting in lungs or legs				Osteopenia or Osteoporosis			
Breast Disease				Rheumatic Fever			
Cancer				Seizures, Convulsions,			
Cataracts				Sickle Cell Disease			
Angina Pectoris				Sleep Apnea			
Congestive Heart Failure				Stroke			
COPD				Thyroid Problems			
Depression, Mental illness				Venereal Disease			
Diabetes				Vitamin Deficiency			
Eczema				Genetic Mutation			

GYN HISTORY	
Did you start your menstrual period before age 12? Select:	Date of LMP: If Post-menopausal, age at menopause:
Number of Pregnancies:	Number of live births:
Age at First Child:	Are you nulliparous (never given birth) Select:
Did you breastfeed: Select:	Bra Size:
Date of Last Breast Imaging:	Have you ever had a breast biopsy: Select: Results:
Have you ever been told you have dense breasts? Select:	
Have you been tested for BRCA1/BRCA2? Select: Results	Have you ever taken estrogen for hormone replacement therapy (HRT)? Select: If yes, how many years? ___
5 year Gail Risk: Lifetime Gail Risk:	Other:

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SOCIAL HISTORY	
Do you have an advance directive? Select:	**Ever had a blood transfusion?** Select:
Smoking Status: Select:	**Smoking-How much?** (list packs per day/week)
Other tobacco use: Select:	**Exercise Activity:** Select:
Alcohol Intake: Select:	**Alcohol Type:** Select:
Drug/Substance Use: Select:	**Drug/Substance Type:** Select:
General stress level: Select:	**Diet:** Select:
Caffeine Use: Select:	**Caffeine type:** Select:
Sexually Active? Select:	**Protected Sex?** Select:
Gender Identity? Select:	**Sexual Orientation:** Select:
Do you have concerns w/ meeting any of the following? Select:	**Transportation difficulties?** Select:
Do you feel safe at home? Select:	**Do you live alone or with others?** Select: