JANET GRANGE, MD

It's Your Life. Whatever It Takes.

Surgeon • Breast Specialist

YOUR HEALTH HISTORY

NAME: _____AGE: _____ DATE OF BIRTH:_____

Are you currently being treated for any medical conditions? _____Yes _____No If yes, please circle

Breast Cancer High blood pressure High cholesterol Low thyroid Allergies Diabetes

Heart problems Asthma Osteoporosis Heartburn Reflux Anxiety Depression

Blood clots Headaches Arthritis Other: _____

Do you take medications on a regular basis? _____ Yes _____ No If yes, please list below

Are you allergic to any medications? _____Yes _____No If yes, please list_____

Have you had any operations? _____Yes _____No. If yes, please circle

Gallbladder removal Hernia repair C-section Hysterectomy Ovary removal Tonsillectomy Appendectomy

Tubal ligation Joint replacement Other: _____

Any family members with breast or ovarian cancer? _____Yes _____No If yes, please list cancer, age of onset and if maternal or paternal

How old were you when you started periods? _____Are your periods regular now? _____Yes ____No _____N/A

How many children do you have? _____ At what age did you deliver your first child? _____

Menopause age: _____ Have you been on Hormone Replacement Therapy ____Yes_____No How many years_____

How many breast biopsies have you had? _____Any precancerous changes like ADH or LCIS? ____Yes _____No

Do you smoke? _____Yes ____No Former Smoker?_____ How often do you drink alcohol per week? _____

Height_____ Weight_____ Are you of Ashkenazi Jewish descent _____Yes_____No

Please circle any symptom you currently have:

Weight loss Fatigue Headaches visual changes Chest pain Shortness of Breath Chronic cough

Abdominal pain Constipation Diarrhea Blood in stool Strokes Seizures Bone pain Joint pain

SIGNATURE: _____DATE: _____