Northern Light
Mercy Hospital

MERCY BREAST CARE
195 Fore River Parkway, Suite 250, Portland, ME 04102
207-553-6800

NEW PATIENT ASSESSMENT FORM

Today's Date: _____

Name: _____ **Birthdate:** _____

Referred by: _____ Primary care provider: _____

Other Providers we should send reports to: _____

WHAT IS THE REASON FOR YOUR APPOINTMENT TODAY? _____

_____

HAVE YOU EVER HAD THE FOLLOWING:

- ☐ Breast Biopsy Details: _____
- ☐ Cyst Aspiration Details: _____
- ☐ Breast Infection Details: _____
- ☐ Breast Cancer Details: _____
- ☐ Breast Surgery** Details: _____

** Include implants, reduction, cancer surgery, surgical biopsies

MENSTRUAL & REPRODUCTIVE HISTORY (Women only):

Age at first period: _____ Most recent period: _____

Did you go through menopause? _____ If yes, when? _____

Age you first gave birth: _____

Did you Breastfeed? _____ If yes, for how long? _____

Have you taken Hormone Replacement Therapy? _____ If yes, for how long? _____

HISTORY OF CANCER IN YOUR FAMILY:

Type of Cancer	**LIST Mother's Relatives** How related to YOU (Aunts/Uncles/Cousins/ Grandparents) and AGE at Diagnosis	**LIST Father's Relatives** How related to YOU (Aunts/Uncles/Cousins/ Grandparents) and AGE at Diagnosis	**LIST Brothers, Sisters, Sons, Daughters, Nieces or Nephews** with this cancer and Age at Diagnosis
Breast Cancer			
Ovarian Cancer			
Uterine Cancer (not cervix)			
Pancreatic Cancer			
Colon Cancer			
Melanoma (not basal or squamous skin cancers)			
Prostate Cancer			
10 or more Colon Polyps in			

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lifetime			

Are you of Ashkenazi Jewish descent? _____ Yes _____ No

Has anyone in your family had cancer-related genetic testing? _____ Yes _____ No

NORTHERN LIGHT MERCY BREAST CARE: NEW PATIENT ASSESSMENT FORM (continued)

Name: _____ Birthdate: _____

MEDICATION ALLERGIES:

Medication Name	Reaction

PAST SURGICAL HISTORY: List all operations you have had performed

	Year Performed	Details
Hysterectomy		
Removal of Ovaries		
Other Surgery (list)		

Any prior problems with Anesthesia: _____

Any pain medicines that did not agree with you: _____

SOCIAL HISTORY:

- ☐ Caffeine Amount per day: _____
- ☐ Alcohol Amount per week: _____
- ☐ Drugs Which drugs: _____
- ☐ Tobacco Currently Amount per day: _____ # Years _____
- ☐ Tobacco in Past Amount per day: _____ # Years _____ When Quit? _____

Current/Former Occupation: _____ Retired? _____

- ☐ Right-handed
- ☐ Left-handed

Please Check if You have had any of the following ***IN THE LAST SIX MONTHS:***

Constitutional
- ☐ Unexplained weight loss/gain
- ☐ Fever/Chills
- ☐ Fatigue

HEENT/Mouth/Neck
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Double vision
- ☐ Sinus problems
- ☐ Allergies
- ☐ Sore throat
- ☐ Mouth sores
- ☐ Dental problems

Respiratory
- ☐ Wheezing
- ☐ Spitting up blood
- ☐ Chronic cough
- ☐ Shortness of breath

Genitourinary
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Difficult/frequent urination
- ☐ Bladder/kidney infections

Endocrine/GYN
- ☐ Abnormal periods
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Night sweats
- ☐ Diabetes
- ☐ Thyroid disease

Psychiatric
- ☐ Frequent crying
- ☐ Mood swings
- ☐ Suicidal thoughts

Heme/Onc/Immunologic
- ☐ Frequent bruising
- ☐ Blood clots Bleeding disorder
- ☐ Enlarged lymph nodes
- ☐ Cancer (other than breast)
- ☐ HIV

Neurologic
- ☐ Stroke/TIA
- ☐ Dizziness
- ☐ Seizures
- ☐ Headache
- ☐ Numbness/tingling
- ☐ Passing out

Musculoskeletal
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Osteoporosis/osteopenia
- ☐ Fibromyalgia

Integumentary
- ☐ Skin rash
- ☐ Skin cancer/growths

Cardiovascular
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Heart palpitations

Gastrointestinal
- ☐ Change in bowels
- ☐ Blood in stool
- ☐ Nausea/Vomiting
- ☐ GERD
- ☐ Stomach ulcers
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ HIV
- ☐ Other_____