

Breast Center of Fort Bend

Kelly S. Dempsey, MD

New Patient Data Sheet

Date: _____

Name: _____ DOB: _____

When was your last mammogram? _____ breast ultrasound? _____

Have you ever had an abnormal mammogram? N Y

Have you ever had breast cancer or a biopsy? N Y date: _____ result: _____

Have you ever had breast surgery? N Y date: _____

What kind? _____

Have you ever had radiation to the breast or chest? N Y

Age at first period? _____ Last period/ age of menopause? _____

Hysterectomy? Yes No Ovaries are: in out

How many times have you been pregnant? _____ How many children have you had? _____

Age at first pregnancy? _____ Did you breast feed? N Y

Do you take hormones or birth control pills? N Y _____

Do you use tobacco? Yes No

Drink alcohol? Never Rarely Occasionally Weekly Daily

What medical problems run in **your family**?

Do your parents, siblings, or children have breast or ovarian cancer? N Y

Specify and at what age: _____

Diabetes Heart disease High blood pressure Other: _____

Cancer: Who and What kind? : _____

List any health problems **you have**:

List any operations **you have had**:

Do you have:

Headaches or seizures? N Y _____

Anxiety or Depression? N Y _____

Vision or hearing problems? N Y _____

Nasal or throat problems? N Y _____

Chest pain or shortness of breath? N Y _____

Nausea, diarrhea or constipation? N Y _____

Weight loss or fevers? N Y _____

Arthritis or muscle problems? N Y _____

Urinary problems? N Y _____