Colette Magnant, M.D., F.A.C.S.
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NEW PATIENT RECORD

PATIENT NAME: ________________________ AGE: __________ DOB: ____________

Problem for which you are being seen? ____

First Noticed when? ____

Any breast lumps? ___________________ Any Nipple discharge? _____________________

Family History of breast cancer? _________ Whom and what age? ____________________

____

Family history of ovarian, colon, thyroid, pancreatic, or prostate cancer? __________________

____

Whom and at what age? ____

REPRODUCTIVE HISTORY:
Date of last menstrual period: _____________ Age of first menstrual cycle:_____________

Age of first full term pregnancy: ____________ Age of Menopause:__________________

History of birth control use: ________________ How many years: ___________________

History of hormone replacement therapy:______________ How many years; _____________

MEDICAL PROBLEMS (check all that apply)

☐ High Blood pressure	☐ Asthma	☐ Thyroid disease	☐ Excessive Bleeding
☐Heart Attack	☐ Emphysema	☐Anemia	☐ Depression / Anxiety
☐Heart Surgery	☐Hepatitis or Jaundice	☐TB	☐Blood Clots
☐Heart Problems	☐ Kidney problems	☐HIV or Aids	☐ Stroke
☐Autoimmune Disorder	☐Ulcers / Reflux	☐High Cholesterol	☐Diabetes

Cancer? ________ If so, what kind? ____
Other: ____

Allergies: (list drug and reaction):

____
____

Family history of medical problems (list relative and medical problem):
____
____

Smoking history: ☐ Yes ☐ No
Number of packs per day: __________ How long: ______________________

Alcohol use: Yes / No
Number of drinks per week: __________________

List **ALL** medications you are currently taking, including over the counter medications and vitamins.

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

REVIEW OF SYSTEMS: Have you recently experienced any of the following problems (Please check all that apply

GENERAL:	☐Fever	☐Fatigue	☐Weight Loss	☐Weight Gain	☐Night sweats
NEUROLOGICAL:	☐Headache	☐Weakness	☐Numbness	☐Fainting	☐Seizure
CARDIAC:	☐Palpitations	☐Chest pain	☐Feet swelling	☐Short of breath lying flat	
RESPIRATORY:	☐Cough	☐Sinus problems	☐Shortness of breath		
ABDOMINAL:	☐Pain	☐No appetite	☐Vomiting	☐Blood in stool	☐Constipation /Diarrhea
URINARY:	☐Difficulty	☐Pain	☐Frequency	☐Urgency	☐Blood in urine /Urinary tract infection
GYN:	☐Spotting	☐Discharge	☐Irregular periods		
M/SKELETAL:	☐Back pain	☐Arthritis	☐Aches and pains		
PSYCHIATRIC:	☐Depression	☐Anxiety	☐Suicidal thoughts		
OTHERS:	☐Increased thirst	☐Tremors	☐Swollen glands	☐Skin problems	☐Feeling excessively hot or cold

______________________________________ ________________________
Signature of Patient Date