Virginia Chiantella, MD, FACS

Specializing in Surgery of the Breast

19415 Deerfield Avenue • Suite 213 • Lansdowne, VA 20176 • Phone: (703) 724-9474 • Fax: (571) 346-1921

www.VCbreastsurgery.com

Please take a moment to fill out this medical history form so that Dr. Chiantella can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Date: _____

First Name: _____ M.I.: ____ Last Name: _____

Date of Birth: _____ Age: _____

Referring Doctor: _____ Primary Care Doctor: _____

OB/GYN: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____

WHAT IS THE REASON FOR TODAY'S VISIT? (Please place an X for all that apply.)

☐ I went for a routine visit and my doctor felt a lump in: ____my right ____my left ____both breast(s) and recommended a follow-up

☐ I found a lump in: ____my right ____my left ____both breast(s).
When did you first notice this? _____

☐ I went for a routine exam, my breast exam was fine, and I was sent for a mammogram which came back abnormal.

☐ My mammogram showed a change when compared to my last mammogram.

☐ I have pain in: ____my right ____my left ____both breast(s).
Please describe your pain: ____constant ____cycles ____same spot ____location varies
When did you first notice this? _____

☐ I have nipple discharge from: ____my right ____my left ____both breast(s).
Color of discharge: _____
When does this occur? ___spontaneously ___only when pressure is applied____ daily ___intermittently
When did you first notice the discharge? _____

☐ Other (Please Specify): _____

Self Exam: I examine my breasts: ____monthly ____intermittently ____rarely ____never

Patient's Full Name: _____ Date of Birth: _____

Medications: (List all current medications.)

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Other Medications: (List all non-prescription drugs, herbs or supplements.)

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Are you taking daily aspirin therapy? ____No ____Yes

Allergies / Intolerance:

Has your skin reacted badly to adhesives, tapes, Band-Aids or sutures? ____No ____Yes
Are you allergic to, or sensitive to, LATEX or latex-containing items? ____No ____Yes
If yes, please describe your reaction: _____

Medication Allergies:

Medication	Reaction

Food and Environmental Allergies:

Past Medical History: (Please place an X for all that apply and add any condition not listed in the boxes below.)

☐ Alcohol / Drug use Disorder	☐ Diabetes, on insulin	☐ Hepatitis	☐ Melanoma
☐ Anemia	☐ Vertigo	☐ Hiatal Hernia	☐ Migraine Headache
☐ Arthritis	☐ Easy Bleeding	☐ High Blood Pressure	☐ Osteopenia
☐ Artificial joint(s)	☐ Dizziness / Vertigo	☐ History of Blood Clot	☐ Osteoporosis
☐ Asthma	☐ Eczema	☐ History of MRSA	☐ Phlebitis
☐ Attention Deficit Disorder	☐ Emphysema / COPD	☐ History of TB	☐ Psoriasis
☐ Bipolar	☐ Esophageal Reflux	☐ HIV Positive	☐ Reduced Kidney Function
☐ Cancer	☐ Fibromyalgia	☐ Hodgkin's Disease	☐ Rheumatoid Arthritis
☐ Cataracts	☐ Gluten intolerance / celiac	☐ Insomnia	☐ Seizure Disorder
☐ Colon Polyps	☐ Graves' Disease	☐ Irritable Bowel	☐ Sleep Apnea – No CPAP/BIPAP
☐ Concussion	☐ Hashimoto's Thyroiditis	☐ Liver Disease	☐ Sleep Apnea – Use: CPAP/BIPAP
☐ Depression	☐ Headache	☐ Lupus	☐ Stroke / TIA
☐ Diabetes, non-insulin	☐ Heart Disease	☐ Lyme Disease	☐ Other condition not above:

Patient's Full Name_____ Date of Birth_____

Surgical History:

Have you ever had: (Please check all that apply.)

☐ A breast cyst aspirated (fluid removed from the breast with a needle)? ____right ____left

☐ A breast core biopsy (needle inserted, not surgery)? ____right ____left

☐ A breast biopsy (surgical - a piece of tissue or lump removed)? ____right ____left

Where was it done? _____
When was it done? _____
Results? _____

Do you have breast implants? ____No ____Yes

Past Surgical History:

Surgery	Date	Surgery	Date

Family History: (Please place an X for all that apply.)

☐ There is no one in my family that I know of with a history of cancer.
Has any family member been tested for the "breast cancer gene" (BRCA 1 or 2)? ____No ____Yes ____ Don't know

My family history is positive for: *(Please list relationship to you, their approximate age at diagnosis and include father's side. Indicate by X the box.)*

Cancer	Relative (sister, uncle, etc.)	Maternal side	Paternal side	Age at Diagnosis	Deceased from this cancer? If yes, at what age?	Age Now
Breast Cancer						
Ovarian Cancer						
Uterine Cancer						
Colon Cancer						
Pancreatic Cancer						
Prostate Cancer						
Thyroid Cancer						
Melanoma						
Other						

Social/Lifestyle History:

Do you currently smoke? ____No ____Yes How many cigarettes per day do you smoke? ____ How many years? _____
Are you a former smoker? ____No ____Yes If yes, # of cigarettes per day?____ # of years? _____ Date you quit? _____
Do you drink alcohol? ____No ____Yes If yes, how often? ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
On a typical day when you drink, how many drinks do you have? ____ 1-2 ____ 3-4 ____ 5-6 ____ 7-9 ____ 10 or more
How often do you have six or more drinks on one occasion? ____ never ____ less than monthly ____ monthly ____ weekly ____ daily/almost daily

Patient's Full Name: _____ Date of Birth: _____

Family Origin: Some races/ethnic groups carry a higher incidence of breast cancer-related genes, which is why we ask you to identify your family origin**.** Check more than one if applicable.
____Eastern European ____Northern European ____Asian ____Western European ____Native American
____Middle Eastern ____African American ____Pacific Islander ____Caribbean ____Central/South American
____Hispanic ____Non-Hispanic ____Ashkenazi (Eastern European Jewish) ____Caucasian ____ Other: _____

GYN History: Age periods started: _____ Age at menopause (if applicable): _____

Have you had a hysterectomy? _____ No

____Yes, including removal of both ovaries.
____Yes, but one ovary, or a piece of ovary, was not removed.
____Yes, but neither ovary was removed.
____Yes, but I don't know if my ovaries were removed.
_____Age at Hysterectomy

Reason for hysterectomy:

____Abnormal bleeding ____Endometriosis
____Fibroids ____Pelvic infections
____Uterine cancer ____Bladder problems
____Pre-Cancer of Cervix ____Cancer of Cervix

Have you ever used estrogen replacement? (This does NOT include vaginally inserted medicines or oral contraceptives.) ____No ____Yes If yes, for how long? _____ Are you using it currently? ____No ____Yes
If you no longer use it, when did you stop? _____
If using, please list your current hormone medication(s) and dose(s):_____
Has the type or dose been changed recently? ____No ____Yes
Have you ever used oral contraceptives? ____No ____Yes If yes, for how long? _____ Are you using it currently? ____No ____Yes

OB History:

Number of pregnancies: _____ Number of live births: _____ Age at first live birth: _____
Have you ever breast fed? ____No ____Yes If yes, total number of months (all children combined): _____
Have you ever taken fertility drugs? ____No ____Yes If you are pregnant, how many weeks? _____ Due date:_____

Review of Systems: (Please only check symptoms that you **currently** experience.)

General / Constitutional Symptoms	__ Fever __ Night sweats __ Weight gain __ Weight loss __ Hot flashes __ Insomnia __Migratory pain
Allergy/Immunology	__ Hives __ Itching __ Rash
Ophthalmologic	__ Double vision __ Blurred vision
ENT	__ Bleeding gums __ Change in voice __ Dizziness __ Hearing loss __ Ringing in ears __ Sinus problem __ Tooth problem __ Difficulty swallowing __ Nosebleed __Sore throat
Endocrine	__ Cold intolerance __ Excessive thirst __ Frequent urination __ Heat intolerance
Respiratory	__ Breathing problems __ Cough __ Shortness of breath at rest __ Shortness of breath with exertion __ Sputum production
Cardiovascular	__ Ankle swelling __ Chest pain at rest __ Chest pain with exertion__ Irregular heartbeat __ Palpitations
Gastrointestinal	__ Blood in stool __ Change in bowel habits __ Nausea __ Stomach problems
Hematology	__ Bleeding problems __ Easy bruising __ Prolonged bleeding
Women Only	__ Postmenopausal __ Irregular menses
Genitourinary	__ Urine leakage __ Difficulty urinating __ Painful urination
Musculoskeletal	__ Back pain __ Disc problems __ Neck pain __ Leg cramps __ Painful joints __ Swollen joints
Skin	__ Discoloration __ Itching __ Rash __ Skin lesion(s)
Neurologic	__ Numbness __ Balance difficulty __ Loss of strength __ Tingling / numbness
Psychiatric	__ Difficulty in concentration __ Memory loss __ Anxiety__ Depressed mood __ Substance abuse

Any complaints not listed above? _____

Height: _____Weight: _____ Bra Size: _____