

CHAND ROHATGI, M.D., F.A.C.S.

A PROFESSIONAL CORPORATION

THE BREAST CARE CENTER & GENERAL SURGERY PRACTICE

3735 NAZARETH ROAD, EASTON, PENNSYLVANIA 18045-1963

PHONE 610-252-1999 FAX 610-252-0573

Date: ___/___/___ Time: ___ am / pm

Name: _____ M / F Pt. ID # _____ D.O.B.: ___/___/___ SS#: _____ M/S/W/D

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____ ext. # _____

PCP: _____ Gyn: _____ Other (s): _____ Referred by: _____

Age: ___ Height: ___ Weight: ___ Race: ___ Occupation: ___ Email _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ D.O.B.: _____ S.S. #: _____

What is the reason for your visit today? _____

What has been done for the problem so far? _____

Current or Past Medical History

Comments:

Liver Failure	Y / N	_____
Kidney Failure	Y / N	Dialysis Needed: Yes / No
Hepatitis or HIV (AIDS)	Y / N	_____
Thyroid or Adrenal Condition	Y / N	_____
Stroke, TIA, or Mini Strokes	Y / N	_____
Excessive Bleeding, Trouble Clotting, Easy Bruising	Y / N	_____
Cancer	Y / N	_____
Other Diseases (Communicable, TB)	Y / N	_____
Diabetes	Y / N	_____
Sleep Apnea	Y / N	CPAP Required: Yes / No
MRSA	Y / N	_____

Lifestyle / Social

Comments:

Smoking	Y / N	# Daily _____ # of Years _____
Alcohol	Y / N	# Daily _____ # Weekly _____
Drugs (Including pain and street drugs)	Y / N	Type _____ # of Years _____

Neuropsychological

Comments:

Seizures or Convulsions	Y / N	_____
Dizziness, Fainting, Fatigue, Weakness	Y / N	_____

Cardiovascular

Comments:

Heart Disease	Y / N	_____
Heart Attack (MI) Or Congestive Heart Failure	Y / N	Date: _____
Heart Surgery, Angioplasty, Stents, Catheterizations	Y / N	Date: _____
Pacemaker or Defibrillator	Y / N	Date Implanted: _____ Brand: _____
High Blood Pressure	Y / N	_____
Low Blood Pressure	Y / N	_____
High Cholesterol	Y / N	_____
Low Cholesterol	Y / N	_____

Respiratory

Comments:

Asthma or Chronic Lung Disease	Y / N	_____
Cough / Wheezing	Y / N	_____
Pneumonia	Y / N	_____
Bronchitis	Y / N	_____
Difficulty breathing when lying down	Y / N	_____

Physician Initials _____ Pt. Initials _____

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Patient Name _____ Pt. ID # _____ D.O.B. ____/____/____

Gastrointestinal

Comments:

Nausea	Y / N	_____
Diarrhea	Y / N	_____
Constipation	Y / N	_____
Abdominal Pain	Y / N	_____
Gas / Belching	Y / N	_____
Indigestion	Y / N	_____
Hiatal Hernia, Reflux, or Stomach Ulcers	Y / N	_____

Female Use Only

Comments:

Any Possibility of Pregnancy	Y / N	Age of first Menstrual Period _____
Last Normal Menstrual Period _____	Number of pregnancies _____	Live Births _____ Abortions _____ Miscarriages _____
Do you or did you breast feed?	Y / N	_____
Do you perform regular breast self exams	Y / N	_____
Breast Pain	Y / N	When _____ For how long _____
Nipple Discharge	Y / N	Color _____ For how long _____
Breast Abscess; Infections	Y / N	_____
Have you ever taken birth control hormones (i.e. pill, patch, injection)	Y / N	_____
Are you currently taking birth control hormones	Y / N	Type _____
In total, how many years have you taken birth control hormones _____		
Have you ever taken medication to assist in getting pregnant?	Y / N	Type _____ How many _____
Have you ever taken Hormone Replacement Therapy?	Y / N	_____
If so, how long were you taking HRT?		_____
Have you ever taken Tamoxifen	Y / N	For How Many Years _____
If yes, please circle one: For Treatment of cancer or DCIS or For Prevention of cancer.		

Please list all previous surgical procedures (invasive and non-invasive)

Please list all Medications and Herbal Supplements both prescribed and/or over the counter that you take

Medication	Dosage	Frequency	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list ALL medications, metals, dyes, latex, or food allergies and the reaction.

Additional Medical History

Physician Initials _____ Pt. Initials _____

GENERAL SURGERY * SURGICAL ONCOLOGY * BREAST SURGERY*
LASER SURGERY * LAPAROSCOPIC SURGERY * COLO-RECTAL SURGERY

www.breastcare-surgery.com