

Peak Wellness Patient History

Name: _____ Date: _____	Do you have a regular doctor or health care provider? <input type="checkbox"/> Yes - Who or What Clinic? _____ <input type="checkbox"/> No
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have:	

When was your last mammogram? Date: _____ Location: _____ <input type="checkbox"/> Never
Were the results of your last mammogram normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Not applicable
When did a health care provider last check your breasts? Date: _____ Location: _____ <input type="checkbox"/> Never
When was your last Pap test? Date: _____ Location: _____ <input type="checkbox"/> Never
Were the results of your last Pap test normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Not applicable
Have you ever had a Pap test that was not normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Not applicable

Have YOU ever been told by a doctor, nurse or other health professional that YOU have:		
	YES	NO
High Blood Cholesterol or Lipids		
High Blood Pressure		
Diabetes		
Diabetes while pregnant		
Heart Attack or Myocardial Infarction, Angina, Coronary Heart Disease, or Stroke?		
Breast Cancer		
Other Cancer - List:		

In the LAST THREE MONTHS, have you had:				
	Right	Left	Both	NO
Breast/armpit lump				
Nipple changes				
Breast/armpit pain				
Breast/armpit skin changes				
Breast size/shape changes				
Other				

Have YOUR FAMILY MEMBERS ever been told by a doctor, nurse or other health professional that THEY have:		
	YES	NO
Father, brother or son who had a stroke or heart attack before age 55?		
Mother, sister or daughter who had a stroke or heart attack before age 65?		
Parents, brother or sister, or child who had diabetes?		
Mother, sister, aunt or daughter who had breast or ovarian cancer?		
Parents, brother or sister, or child who had colon cancer?		

Your Health History:	YES	NO
Have you ever had breast surgery? Why? _____ When? _____		
Are you currently breastfeeding?		
Do you have breast implants?		
Do you have regular menstrual periods?		
Do you have any vaginal bleeding that isn't normal?		
Have you had a hysterectomy?		
If you had a hysterectomy, was it due to cancer?		
Is your immune system compromised? HIV AIDS & Immunosuppressant drugs		
Did your mother take DES when she was pregnant with you?		
Have you had any other surgeries? If yes, explain _____		
Have you ever been kicked, slapped, shaken or hurt by someone?		
Are you using birth control now?		
Do you want birth control TODAY?		

Medications: Do you take any of the following?		
	YES	NO
Cholesterol or Lipid Medication		
High Blood Pressure Medication		
Diabetes Medication		
Calcium		
Hormone Replacement Therapy		
Other – List:		

Patient Signature: _____ Provider Signature: _____

Cut patient label and place here.