Barnabas Health Ambulatory Care Center | RWJBarnabas HEALTH

NAME:

DATE OF SERVICE:

MEDICAL RECORD NUMBER:

REFERRING PHYSICIAN:

The Breast Center
PATIENT HISTORY FORM

NAME: _____ **DATE OF BIRTH:** _____

Preferred Language for *discussing* healthcare ☐ English ☐ Spanish ☐ Russian ☐ Other *(specify)* _____

☐ None **SURGERY/ILLNESS HISTORY** **BREAST IMPLANTS YES ☐ NO ☐**

DATE	SURGERY/ILLNESS

MEDICAL HISTORY - PLEASE INFORM THE TECHNOLOGIST IF YOU HAVE A HISTORY OF FAINTING OR DIZZY SPELLS PRIOR TO YOUR PROCEDURE

_____ NONE _____ DIABETES _____ HEPATITIS _____ ARTHRITIS _____ CANCER
_____ ASTHMA _____ KIDNEY _____ HYPERTENSION _____ THYROID _____ TB
_____ CARDIAC _____ EPILEPSY _____ PSYCHIATRIC _____ ULCER _____ FAINTING
_____ OTHER - PLEASE SPECIFY _____

Could you be pregnant? ☐ Yes ☐ No Date of Last Menstrual Period? _____ / _____ / _____

ALLERGIES ☐ None
LATEX _____ REACTION _____
MEDICATION _____ REACTION _____
FOOD _____ REACTION _____
OTHER _____ REACTION _____

Smoking: ☐ No ☐ Yes Amount: _____ Alcohol Consumption: ☐ No ☐ Yes Amount: _____

PATIENT SIGNATURE: _____

FOR BREAST CENTER STAFF USE ONLY

	No	Yes	If Yes, specify
1. Symptoms of Abuse	☐	☐	
2. Nutritional Hydration Needs Identified	☐	☐	
3. Functional Needs Identified	☐	☐	
4. Communication Barriers (language, cognitive, cultural)	☐	☐	
5. Physical Barriers (vision, hearing, physical limitations, physical disabilities)	☐	☐	
6. Learning Barriers (emotional, development, or mental disorders)	☐	☐	

Patient Learns Best ☐ Written material ☐ Verbal Explanation ☐ Demonstration ☐ Visual Aids *(Handouts, Videos, DVD, CD, etc.)* ☐ Other *(specify)* _____

Preferred Language *for receiving written materials*

☐ English ☐ Spanish ☐ Russian ☐ If other (specify) _____ language line used and verbal instructions reviewed with patient

Translator Services needed ☐ No ☐ Yes ☐ Language Line ☐ Other *(specify)* _____

PROCEDURE _____ **VITAL SIGNS PRE-PROCEDURE** B/P _____ PULSE _____

Pain Assessment using the Pain Assessment scale

Pain/Discomfort: ☐ NO ☐ YES - Where? _____ ☐ Acute ☐ Chronic

Type: ☐ Burning ☐ Dull ☐ Pressure ☐ Heavy ☐ Sharp ☐ Cramping
☐ Shooting ☐ Stabbing ☐ Tenderness ☐ Other _____

Duration: ☐ Constant ☐ Intermittent Pain interferes with sleep: ☐ NO ☐ Yes _____

What Relieves Pain? ☐ Resting ☐ Heat ☐ Cold ☐ Medication _____ ☐ Other _____

PAIN SCALE *(circle)* 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Comfort goal number _____ Pre procedure score _____ Post procedure score _____ Ice Pack ☐ Yes ☐ No Medication ☐ Yes ☐ No

☐ Patient offered education on smoking cessation ☐ Patient received Patient Safety Education ☐ Patient verbalized understanding

☐ Other (explain) - _____

TECH/RN Signature and Additional Comments _____

Date/Time: _____