AMBULATORY CARE RECORD
PATIENT SUMMARY

PATIENT NAME:_______________________________**AGE:**_____**DOB:**___________

Problem for which you are being seen:____

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First noticed when:___________________________**Location:**______________________
Any breast lumps?____
Any nipple discharge?____

Family history of breast cancer_________ Whom and at what age_____________________

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Family history of ovarian cancer________Whom and at what age_____________________

Reproductive History:
Age of first menstrual cycle_____ Age of first full term Pregnancy_____# of Pregnancies_____
# of Children_____# of Miscarriages_____# of Abortions_____Age at Menopause___________
History of Birth control pill use___________How many years_______Still on: Y N
History of Hormone Replacement Therapy_______How many years_____ Still on: Y N

Medical Problems: Circle all that apply

High Blood Pressure	Asthma	Thyroid Disease	Excessive Bleeding
Heart Attack	Emphysema	Anemia	Depression/Anxiety
Heart Surgery	Hepatitis or Jaundice	Autoimmune Disorder	
Heart Problems	Kidney Problems	TB	
Stroke	Ulcers	HIV or AIDS	
High Cholesterol	Diabetes	Arthrtitis	

Cancer-What kind?____

Other-Please list____

Previous surgical procedures: List with year of surgery

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____
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Medications: List drug, dose and how often

____
____
____
____

Allergies: List drug and reaction

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Family History:

Mother – Alive/Died

Cause of death______________________________

Medical problems______________________________

Father – Alive/Died

Cause of death______________________________

Medical problems______________________________

Smoking History:

Yes/No

# of packs/day____________________

Duration____________________

Alcohol Use:

Yes/No

# of drinks/week__________

Review of systems: Have you recently experienced any of the following list of problems – please circle all applicable)

General:	Fever	Fatigue	Weight loss	Weight gain
	Night sweats			
Neurological:	Headache	Weakness	Numbness	Fainting
	Seizures			
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 infections	
GYN:	Spotting	Discharge	Irregular periods	
M/Skeletal:	Back pain	Arthritis	Aches & pains	
Psychiatric:	Depression	Anxiety	Suicidal thoughts	
Others:	Increased thirst		Tremors	Swollen glands
	Skin problems		Feels excessively hot/cold	

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Signature of Patient Date