THE HOFFBERGER
Breast Center
AT MERCY

AMBULATORY CARE RECORD

UPDATE

PATIENT NAME:______________________________ **AGE:**________ **DOB:**__________

Any change in medical history?______________________________
List ALL Allergies.______________________________
Any surgery since last visit?______________________________

List ALL medications you are currently taking, including over the counter medications and vitamins.

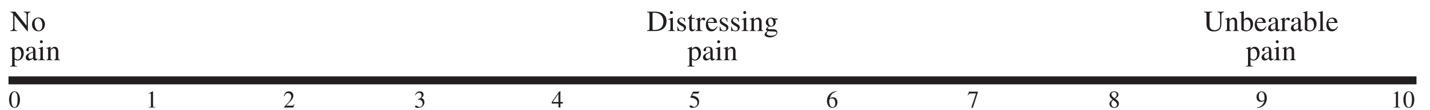
1. ________________	6. ________________
2. ________________	7. ________________
3. ________________	8. ________________
4. ________________	9. ________________
5. ________________	10. ________________

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	Shortness 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 infection				
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		

In order to assess your pain level during your visit, please complete the following pain scale information:

CHOOSE A NUMBER FROM 0 TO 10 THAT BEST DESCRIBES YOUR PAIN



If you are experiencing pain, please indicate location:______________________________

____

Signature of Patient **Date**

F784561