

**COLUMBUS W. FLOYD, M.D. 2800 E. BROAD ST., SUITE 500 MANSFIELD, TX 76063**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Family History: Has anyone in your family had any of the following? If "Yes", indicate that person's relation to you, otherwise, list "No":**

High Blood Pressure \_\_\_\_\_ Heart Attack \_\_\_\_\_

Heart Failure \_\_\_\_\_ Stroke \_\_\_\_\_

Diabetes \_\_\_\_\_ Anything that runs in the family? \_\_\_\_\_

Cancer- Who and What kind? \_\_\_\_\_

**REVIEW OF SYSTEMS: Have you recently had any of the following? (Please state "yes" if present.)**

**CONSTITUTIONAL:** Wt. loss or gain (if so, how much)? \_\_\_\_\_ Cold or flu \_\_\_\_\_

**NEUROLOGICAL:** Blindness \_\_\_\_\_ Fainting \_\_\_\_\_ Weakness on one side \_\_\_\_\_ Seizures \_\_\_\_\_

**RESPIRATORY:** Smothering \_\_\_\_\_ Waking up short of breath \_\_\_\_\_ Persistent cough \_\_\_\_\_

**GASTROINTESTINAL:** Indigestion \_\_\_\_\_ Vomiting \_\_\_\_\_ Diarrhea \_\_\_\_\_ Blood in stool \_\_\_\_\_ Constipation \_\_\_\_\_

**URINARY:** Trouble passing urine \_\_\_\_\_ Frequency \_\_\_\_\_ Urgency \_\_\_\_\_ Pain \_\_\_\_\_

**MUSCULOSKELETAL:** Back trouble \_\_\_\_\_ Arthritis \_\_\_\_\_ Pain \_\_\_\_\_

**SKIN CONDITION:** \_\_\_\_\_ Explain: \_\_\_\_\_ **LYMPHATIC:** Swelling in glands: \_\_\_\_\_

**PSYCHIATRIC:** Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Suicidal thoughts \_\_\_\_\_

**ENDOCRINE:** Excessive thirst or urination \_\_\_\_\_ Feeling too hot or cold \_\_\_\_\_

**Breast Health Information: Please list any previous breast problems or breast surgery:** \_\_\_\_\_

**Family Members with Breast Cancer? No** \_\_\_\_\_ **Yes** \_\_\_\_\_ (Please list approximate age when diagnosed).

First degree relatives: Self \_\_\_\_\_ Sister(s) \_\_\_\_\_ Mother \_\_\_\_\_ Daughter(s) \_\_\_\_\_

Mother's side: Grandmother \_\_\_\_\_ Aunt(s) \_\_\_\_\_ Cousin(s) \_\_\_\_\_ Other \_\_\_\_\_ Men \_\_\_\_\_

Father's side: Grandmother \_\_\_\_\_ Aunt(s) \_\_\_\_\_ Cousin(s) \_\_\_\_\_ Other \_\_\_\_\_ Men \_\_\_\_\_

**Age menstrual periods began:** \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_ Number of children \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ Age at delivery of first child \_\_\_\_\_

Have you ever taken birth control pills? \_\_\_\_\_ Approximate dates: \_\_\_\_\_

Have you ever taken hormones? \_\_\_\_\_ Approximate dates: \_\_\_\_\_

Do you take hormones now? \_\_\_\_\_ What kind? \_\_\_\_\_ Dose \_\_\_\_\_ How long? \_\_\_\_\_

**REVIEWED BY** \_\_\_\_\_ **DATE** \_\_\_\_\_