

Breast Biopsy Patient History Form

To be completed by the patient:

Name: _____ DOB: _____

Phone: _____ Height: _____ Weight: _____

Allergies: _____

Allergy to Latex: Yes No

Yes No

- 1) Are you pregnant or possibly pregnant?
- 2) Do you have an artificial heart valve? If yes, explain: _____
- 3) Do you take prophylactic antibiotics prior to a dental visit? If yes, reason: _____
- 4) Do you have any blood thinning disorders, history of bleeding or take any type of blood thinner? If yes, what kind? _____
- 5) Have you had a joint replacement surgery in the last six months? If yes, which joint and side? _____
- 6) Are you having pain or have you had pain recently? If yes, answer the questions below.

Location of pain? _____

Describe the pain: _____

Level of pain on scale of 0 - 10 (0 = no pain 10 = severe pain) _____

What aggravates the pain? _____

What relieves the pain? _____

Surgical/Medical History:

I have filled out this form and verify that the information is correct.

Patient/Legally Authorized Person Signature Printed Name Title (Self, Spouse, Nurse, etc.) Date Time

Qualified Staff / Interpreter Signature OR Phone _____
 Video _____
Print Qualified Staff / Interpreter Name ID Number Language Interpreted

For Staff use only

R.N. Comments: _____

Staff Authentication Printed Name Date Time

Patient Label or	
Patient Name _____	<input type="checkbox"/> F <input type="checkbox"/> M
DOB _____	MRN _____