Breast Biopsy Patient History Form

To be completed by the patient:

Patient's phone #: _____ Height: _____ Weight: _____

YES	NO	
☐	☐	Are you pregnant or possibly pregnant?
☐	☐	Allergies? If yes, please list: _____
☐	☐	Are you allergic to latex?
☐	☐	Do you have any blood thinning disorders, history of bleeding or take any type of blood thinner? If yes, what kind? _____
☐	☐	Have you had a joint replacement in the past 6 months? If yes, which joint & side? _____
☐	☐	Do you have an artificial heart valve? If yes, explain _____
☐	☐	Do you take prophylactic antibiotics before dental visits? If yes, reason _____
☐	☐	Are you currently experiencing pain or have you experienced pain recently? If yes, Location of pain: _____ Describe the type of pain you are having: _____ Level of pain on a scale from 0 to 10; 0= no pain and 10= severe pain: _____ What, if anything, aggravates the pain? _____ What, if anything, relieves the pain? _____

Surgical/Medical History:

_____

I have filled out this form and verified that the information is correct:

_____ _____ _____ _____/_____

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

☐ Phone

_____OR ☐ Video _____ _____ _____

Qualified Staff/Interpreter Signature | (Check) | Print Qualified Staff/Interpreter Name | ID Number | Language Interpreted

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For Staff use only

R.N. comments: _____

_____

_____ _____ _____ _____

Staff Authentication | Printed name | Date | Time

AdventHealth

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Patient Label or

Patient Name_____ ☐Female ☐Male

DOB_____ MRN_____