ALASKA BREAST &
COSMETIC CENTER
Health. Hope. Confidence.

Are you currently under a Physician's care? If yes, who and which facility?:

____

Date of last physical exam: _________ Date of last Mammogram: _________ Have you ever had BRCA Testing: ☐ YES ☐ NO

Age started period: _________ Age started Menopause: _________ Age at first delivery: _________

Breast Feeding: ☐ YES ☐ NO Number of Pregnancies: _________ Number of Miscarriages: _________

Please list all medications: (Please list strength) ______________________________________

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____

Allergies: ____

____

Have you ever any significant problems with anesthesia? ☐ YES ☐ NO Explain: ______________________

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	YES	NO
Are you pregnant or suspect you may be?	☐	☐
Do you use any birth control medications? Name: ______________________________		
Have you ever been treated for or been told you might have heart disease or a heart condition?	☐	☐
Do you have high or low blood pressure? Please specify: ______________________________	☐	☐
Do you have a pacemaker or an artificial heart valve implant?	☐	☐
Have you ever had rheumatic fever?	☐	☐
Have you used ACUTANE? If yes, when? ______________________________	☐	☐
Have you ever taken the diet pill PHEN-FEN or PHENTERMINE?	☐	☐
Have you ever had a serious illness? ______________________________	☐	☐
Have you ever had Plastic Surgery? ______________________________	☐	☐
Have you ever had Radiation Treatment, Chemotherapy? When: ______________________________	☐	☐
Do you have any blood disorders such as anemia, leukemia and/or immunodeficiency disorders?	☐	☐
Have you ever bled excessively after bring cut or injured?	☐	☐
Do you have acid reflux, hiatal hernia, ulcers or difficulty swallowing? (Please circle one)	☐	☐
Do you have any kidney or liver problems? (Please circle one)	☐	☐
Do you have a history of sleep apnea?	☐	☐
Are you HIV positive?	☐	☐
Do you have or have you tested positive for Hepatitis?	☐	☐
Do you have or have you had Tuberculosis?	☐	☐
Do you smoke, chew, use snuff or any other forms of tobacco, including cigars?	☐	☐
Would you accept blood in an emergency?	☐	☐

Do you have any other condition or problem not listed? (Please list) ______________________________

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I certify that the above information is complete and accurate

Patient Name (print): ______________________________

Patient Signature: ______________________________ Date: _______________