The Breast Center
Milford Regional Medical Center
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Patient Name:_____ Age:____ Date of Birth:_____ Sex ☐ M ☐ F

Height:_____ Weight:_____ **BMI: HOSPITAL - RN USE ONLY**

Date of Surgery:_____ Type of Surgery:_____

Surgeon's Name:_____ Primary Care MD Name:_____

Do you have a Health Care Proxy? ☐ Yes ☐ No If yes, please provide copy:_____

What is your preferred language? English ☐ Other:_____

ALLERGIES: (include medications, LATEX, contrast dye, tape, food, etc.)

Allergic to:	Reaction:	Allergic to:	Reaction:

MEDICATIONS: (Include dietary supplements, herbal medications and recent steroids)
Please fill out the **OUTPATIENT SERVICES MEDICATION RECONCILIATION FORM.**
Please do not fill in LAST DOSE.

HABITS:

- Do/did you ever smoke?_____ ☐ Yes ☐ No
  How many packs per day?_____ How many years?_____
  If applicable, when did you quit?_____
- Do you consume alcohol?_____ ☐ Yes ☐ No
  If so how many drinks per week? _____
  If applicable, when did you quit?_____
- Do you use recreational drugs?_____ ☐ Yes ☐ No
  Type:_____

FUNCTIONAL STATUS:

- Do you require assistance with any of the following: bathing, toileting , dressing, getting in or out of bed? _____ ☐ Yes ☐ No
  If yes: ☐ some activities ☐ all activities

PREVIOUS SURGERY:

Date	Operation/Procedure	Date	Operation/Procedure

- Have you or any relative ever had a major problem related to receiving anesthesia?_____ ☐ Yes ☐ No
  (i.e. difficult airway, Malignant hyperthermia, unexplained high fevers, etc.)
  If yes, please describe _____

Patient Name:_____ Date of Birth:_____

OBSTRUCTIVE SLEEP APNEA (OSA)

Have you been diagnosed with obstructive sleep apnea (OSA)?--------- ☐ Yes ☐ No

Do you use CPAP/BiPAP Machine?---------- ☐ Yes ☐ No

OSA STOP-BANG SCREEN

(if answered Yes to OSA question above, Skip the following 5 questions)

1. Do you snore loudly (loud enough to be heard through closed doors)?-- ☐ Yes ☐ No
2. Do you often feel tired, fatigued or sleepy during the daytime?---------- ☐ Yes ☐ No
3. Has anyone observed you stop breathing during your sleep?---------- ☐ Yes ☐ No
4. Do you have or are you being treated for high blood pressure?------ ☐ Yes ☐ No
5. Neck circumference > 17 inches male?---------- ☐ Yes ☐ No
   > 16 inches female?---------- ☐ Yes ☐ No

OSA STOP-BANG SCREEN

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6. ☐ BMI > 35
7. ☐ Age > 50
8. ☐ Male

Consider sleep study referral if > 3 "yes" responses to the eight questions.

EXERCISE CAPACITY:

- Do you exercise regularly---------- ☐ Yes ☐ No
- Can you climb 1 flight of stairs without shortness of breath or chest tightness?---------- ☐ Yes ☐ No

HEART AND VASCULAR DISEASE:

- Heart Attack / MI / Cardiac Stents:---------- ☐ Yes ☐ No Date:_____
- Chest Pain / Angina:---------- ☐ Yes ☐ No
- Congestive Heart Failure:---------- ☐ Yes ☐ No
- Irregular Heart Beat:---------- ☐ Yes ☐ No
- Pacemaker / Automatic Internal Cardiac Defibrillator (AICD):---------- ☐ Yes ☐ No
- Heart Murmur / Heart Valve problems / "hole in heart"---------- ☐ Yes ☐ No
- Have you been told to take antibiotics before surgical or dental procedures? ☐ Yes ☐ No
- High Blood Pressure:---------- ☐ Yes ☐ No
- Peripheral Vascular Disease:---------- ☐ Yes ☐ No

Special Tests: (stress test, echocardiogram, cardiac cath, etc.)

Date	Test	Place

Cardiologist (heart doctor):---------- ☐ Yes ☐ No

Name:_____ Date of last appointment:_____

LUNG AND RESPIRATORY DISEASE:

- Lung or Breathing Problem:---------- ☐ Yes ☐ No

  ☐ Asthma ☐ Emphysema/COPD ☐ Bronchitis ☐ Home O2

IMMUNE DISORDERS/OR IMMUNOSUPRESSION

☐ Scleroderma ☐ Lupus

- History fo transplant (if so what kind?) _____
- Any prescription drugs _____

ENDOCRINE DISORDERS:

- Diabetes:---------- ☐ Yes ☐ No

  ☐ Insulin ☐ Tablets Only
- Thyroid or Adrenal problems?---------- ☐ Yes ☐ No

  If yes, describe: _____
- Steroids for Chronic Conditions?---------- ☐ Yes ☐ No

KIDNEY DISORDERS:

- Kidney Disease (requiring treatment):---------- ☐ Yes ☐ No

  If yes, describe:_____ Hemodialysis: ☐ Yes ☐ No

Patient Name:_____ Date of Birth:_____

DIGESTIVE SYSTEM DISORDERS:

- Heartburn/Reflux (requiring treatment):---------- ☐ Yes ☐ No

LIVER DISEASE:

- Hepatitis:---------- ☐ Yes ☐ No

  Type: A, B, C (if known):_____

- Cirrhosis / Ascites / Jaundice---------- ☐ Yes ☐ No

NEUROLOGIC DISORDER:

- Stroke or TIA (mini stroke):---------- ☐ Yes ☐ No Date:_____
- Seizures/Epilepsy:---------- ☐ Yes ☐ No
- Fainting Spells/Syncope:---------- ☐ Yes ☐ No
- Nervous System Disease (i.e. MS, Parkinsons, etc.):---------- ☐ Yes ☐ No

  If yes, describe:_____

- Mental Health Disorder (anxiety, depression, etc. requiring treatment)---------- ☐ Yes ☐ No
- Cognitive Disorder: (i.e. Alzheimer's, dementia, etc.) ---------- ☐ Yes ☐ No

MUSCULOSKELETAL DISORDERS:

- Muscle Disease (i.e. muscular dystrophy) or Family History:---------- ☐ Yes ☐ No

  If yes, describe:_____

- Joint / Back Problem (i.e. arthritis, TMJ disease, etc):---------- ☐ Yes ☐ No

  If yes, describe:_____

BLEEDING DISORDERS:

- Do you bruise easily?---------- ☐ Yes ☐ No
- Do you take a blood thinner (i.e. aspirin, Coumadin, Plavix, other, etc.)?---------- ☐ Yes ☐ No
- Do you have sickle cell disease or trait?---------- ☐ Yes ☐ No
- Have you had a blood transfusion in the past?---------- ☐ Yes ☐ No

CANCER:

- Have you been treated for cancer?---------- ☐ Yes ☐ No

  If yes, list type:_____

- Radiation Therapy:---------- ☐ Yes ☐ No
- Chemotherapy:---------- ☐ Yes ☐ No

INFECTIOUS DISEASE:

- Do you have a history of any of these infectious diseases?---------- ☐ Yes ☐ No ☐ Do not Know

  ☐ TB ☐ MRSA ☐ CDiff ☐ Other:_____

PAIN:

- Do you have any pain?---------- ☐ Yes ☐ No

  Location:_____ Functional Pain Level (0-10)_____/10

- Chronic Pain Disorder?---------- ☐ Yes ☐ No

  If yes, describe:_____ Treated with Opioids? ☐ Yes ☐ No

For Women:

- Is there a possibility you may be pregnant?---------- ☐ Yes ☐ No

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- Date of last menstrual period:_____
- Patient offered pre-op pregnancy testing education:---------- ☐ Yes ☐ N/A

RN Reviewer:_____ **Date:**_____ **Time:**_____

Milford Regional Medical Center

OUTPATIENT SERVICES
MEDICATION RECONCILIATION FORM

Patient Name: *PATIENT TO FILL OUT ONLY SECTIONS 1 & 2

Please bring this medication record with you to your physician's office or upon return to the hospital

1. Date and Time: ____/____

Allergy/Intolerance	Reaction(s)	Allergy/Intolerance	Reactions(s)	Allergy/Intolerance	Reaction(s)
1.		3.		5.	
2.		4.		6.	

Patient's Pharmacy: _____ Pharmacy address: _____

2. Current Medication(s) List Prior to Admission

List all medications, nutritional and herbal supplements, and pumps or patches used prior to this visit or admission.

Source: ☐ Patient ☐ Family ☐ Provided List ☐ Other _____

Obtained by: _____

Medication (Include Strength)	Directions (Dose, Route, Frequency)	Indication (Reason)	*Medical Staff to complete box below* Last Dose (Date/Time) *LEAVE BLANK	Resume Meds on Discharge	Resume Date/Time
1.				YES NO	
2.				YES NO	
3.				YES NO	
4.				YES NO	
5.				YES NO	
6.				YES NO	
7.				YES NO	
8.				YES NO	
9.				YES NO	
10.				YES NO	

Based on your visit to Milford Regional Medical Center, you may safely continue only the medications circled YES in the "Resume Meds on Discharge" column above. If you have any questions, please contact your primary physician or surgeon.

3. Prescriptions Given at Discharge

☐ "Pain Management with Opioids" sheet given

Medication (Include strength)	Dose/Route/Frequency	Indication	Next Dose	Med Info Given
1.				
2.				
3.				

☐ You should not take Acetaminophen (Tylenol) products while taking _____

☐ You may take Acetaminophen (Tylenol) products if needed after _____

☐ You may take Ibuprofen (Motrin/Advil/Aleve) products if needed after _____

MD Signature: _____ Date: _____ Time: _____

RN at Discharge Signature: _____ Date: _____ Time: _____

Patient Signature: _____ Date: _____ Time: _____

Prohibited Abbreviations: u, qd, qod, MS, MS04, MgSO4, ug, .1 (use 0.1), 1.0 (use 1), SPA, CTX, IU

USE BALL POINT PEN ONLY

BREAST HEALTH Please indicate your Bra Size: _____		
Breast lump	○ Yes ○ No	○ Right ○ Left
Nipple discharge	○ Yes ○ No	○ Right ○ Left
Nipple inversion	○ Yes ○ No	○ Right ○ Left
Have you had any breast cyst(s) aspirated?	○ Yes ○ No	○ Right ○ Left
Have you had any prior breast biopsy or surgery?	○ Yes ○ No	○ Right ○ Left

GYNECOLOGIC HISTORY:	
Age when menstrual periods began:	
First day of last menstrual period:	
If menopausal, at what age did that begin?	
Number of children born:	
Age at first full-term pregnancy:	
Did you breast feed?	○ Yes ○ No If Yes, how many months _____
Are you currently pregnant?	○ Yes ○ No
Have you ever taken birth control pills?	○ Yes ○ No If Yes how many years _____
Have you ever taken any other hormones? *(i.e. Estrogen, Premarin etc.)*	○ Yes ○ No If Yes how many years _____
Have you ever had fertility treatments?	○ Yes ○ No

FAMILY HISTORY	
Are you of Ashkenazi Jewish Heritage? YES○NO○	Have you or family members had genetic testing? ○ Yes ○ No
If "yes" to genetic testing, when and what was the result?	When: Result:

Please list blood relatives who had BREAST CANCER or OVARIAN cancer or OTHER cancers

Relative	Paternal/maternal (P/M)	Age at diagnosis	Type of cancer	Current status
	○ P ○ M			○ Living ○ Deceased
	○ P ○ M			○ Living ○ Deceased
	○ P ○ M			○ Living ○ Deceased
	○ P ○ M			○ Living ○ Deceased