Breast Biopsy Patient History Form

FLORIDA HOSPITAL

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
_____	_____	_____	_____	_____

_____ OR ☐ Phone ☐ Video _____ _____ _____

Qualified Staff / Interpreter Signature | 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 _____ ☐ F ☐ M

DOB _____ MRN _____