



**AUERBACH BREAST CENTER
PATIENT MEDICAL HISTORY**

Chronic Medical Problems:

Past Surgeries or Hospitalizations:

Current Medications or Herbal Supplements:

Please include your daily dose.

Medication Allergies/Reaction:

Please list any of your physicians (primary care, gynecologist, other) who you would like us to communicate with regarding your care at the Comprehensive Breast Center:

- 1. _____ Location: _____
- 2. _____ Location: _____
- 3. _____ Location: _____

Patient Signature _____ Date: _____

A new form should be completed every 12 months