Breast Surgery

Name:	Date of Birth: YYYY / MM	/ DD
Nationality:	/ /	Age:
Adress: ¯	Phone No. ()	_
	Emergency Contact ()	_
	Name: Rela	itionship:
※Do you have an "Individual Number Card"?	()YES • ()NO	
	()YES · ()NO	
Described Date:yearmonthdat	D.	ID:
What made you come to our clinic today?		
() Breast cancer sreening (No symtoms)	() Pointed out abnormalities in	n the examination
() Introduced by other medical institutions	()Have symptoms <mark>※</mark>	
※If you have symtoms, please describe in detail.		
From when ?:		
Breast pain: ()YES (Rt. · Lt.) · ()NO	Rt. Lt.	
Breast mass : ()YES (Rt. ⋅ Lt.) ⋅ ()NO		
Secretion from nipple : ()YES (Rt. \cdot Lt.) \cdot ()NO		/\ \
Have you ever had breast cancer examination in the	past?:()YES · ()NO	
When was the last examination?: year n	nonth or years ago	
Type of examination: (Palpation · Mammography ·	Ultrasound · MRI · Biopsy)	
About medical history.		
Breast disease: Mastopathy · Fibroadenoma · Ma	stitis · Breast cancer · ()
Gynecological disease: Myoma · Uterine cancer ·	Ovarian cancer • ()
Breast augmentation : Implant (Silicone · Saline)	• (
Indwelling surgery: Pacemaker · Ventriculoperitone	eal shunt · ()
Hormone therapy: Hormone replacement · Oral pill	l · Fertility therapy · ()
Other: Asthma · Diabetes · Hypertension · Hyper	lipidemia · ()
Do you have breast cancer or ovarian cancer patient)NO
Grandmother · Mother · Aunt · Sister · Cousin ·	()	
When was the last menstrual period?	from year month	day
	or menopause <mark>※</mark> age :	
About pregnancy, birth and breastfeeding.		
①Number of pregnancies : times	②Number of birth : time	es
③Is there a possibility of pregnancy?:	()YES※Pregnancy period:	weeks • ()NO
4Are you currently breastfeeding?:	()YES · ()NO	
**When did you stop breastfeeding?:	year month or	years ago
Do you have any food or medication allergy? : ()	YES () · ()NO
How did you get to know our clinic?		
Introduced by friend · Internet · Advertisement · Liv	ving neighborhood · ()