

BREAST HEALTH HISTORY

Name: _____

DOB: _____

What is the reason for today's visit? _____

- | | | | | | |
|--|----|----|---|----|----|
| <input type="checkbox"/> Breast pain or discomfort | Lt | Rt | <input type="checkbox"/> Treatment of breast cancer | Lt | Rt |
| <input type="checkbox"/> Breast lump | Lt | Rt | <input type="checkbox"/> Consult regarding a breast tumor | Lt | Rt |
| <input type="checkbox"/> Abnormal mammogram | Lt | Rt | <input type="checkbox"/> High risk for cancer in family | Lt | Rt |
| <input type="checkbox"/> Second opinion | Lt | Rt | Other _____ | | |

Should we send a report to your physician? _____ If yes, who? _____

Breast Health History

What is your bra size? _____

What is your ancestry? _____

Do you do self breast exams? No Yes

Do you have any of these symptoms? If yes, before, during or after your period?

Tenderness	No	Yes	When _____	Which breast?	Lt	Rt
Swelling	No	Yes	When _____	Which breast?	Lt	Rt
Nipple discharge	No	Yes	When _____	Which breast?	Lt	Rt
Lump or mass	No	Yes	When _____	Which breast?	Lt	Rt
Other:	_____					

Reproductive History

At what age did you start your menstrual period? _____

Date of last menstrual period? _____

If stopped, What age were you? _____

Have you had a hysterectomy? No Yes

Were your ovaries removed? No Yes

How many times have you been pregnant? _____

How many children do you have? _____

How old were you when you had your first child? _____

Did you breast feed? No Yes

Have you ever taken birth control pills? No Yes

Have you ever taken hormone replacement? No Yes

How long? _____ Age started: _____

How long? _____ Age started: _____

Family Breast History

Has anyone in your family had breast cancer? No Yes

If yes, please note at what age: _____

Mother _____

Maternal Aunt _____

Paternal Aunt _____

Daughter _____

Maternal Grandmother _____

Paternal Grandmother _____

Sister _____