BREAST HEALTH HISTORY

Emerson Hospital
Premium Care. Personal Touch.
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Name: ____ DOB: _____________

What is the reason for today's visit? ____

☐ Breast pain or discomfort	Lt	Rt	☐ Treatment of breast cancer	Lt	Rt
☐ Breast lump	Lt	Rt	☐ Consult regarding a breast tumor	Lt	Rt
☐ Abnormal mammogram	Lt	Rt	☐ High risk for cancer in family	Lt	Rt
☐ 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 heritage? _______________________

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 ______________________