

Breast Health History Form

Patient's Name: _____ **Date:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** _____

Do you have any family history of breast cancer? Self Mother Sister Daughter None
Maternal – Grandmother Aunt Cousin *Paternal* – Grandmother Aunt Cousin

Do you have any diagnosed breast conditions? None Fibrocystic Cystic Other _____

When was the date of your last mammogram? _____
 Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

When was the date of your last breast ultrasound? _____ Were both breasts imaged? Y N
 Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

Date of last physical breast exam by a doctor _____ Normal Lump found – R L Breast

Any breast biopsies? When and what type (i.e. needle, excisional)? _____ R L Breast

What was found on the biopsy? Cancer Other _____ R L Breast

Any breast surgeries? When and what was done? _____ R L Breast

Have you had a mastectomy? If yes, when? _____ R L Breast

Any breast reconstruction? When and what was done? _____ R L Breast

If you have had any radiation treatment, when was it last performed? _____ R L Breast

How many children do you have? _____ At what age was your first full term pregnancy? _____

How many of your children did you nurse over 1 month? _____ Are you currently nursing? Y N

Are you currently pregnant? Y N Current cycle day (number of days since first day of period) _____

If you've used birth control pills, at what age did you start? _____ How many years have you taken them? _____

Are you currently taking them? Y N

If you have passed menopause, at what age did it begin? _____

If you are taking hormone replacement, at what age did you start? _____ How many years taken? _____

Are you currently taking hormones? Y N (check only if by prescription): Estrogen Progesterone

Are you currently using herbs or supplements to stimulate or simulate estrogen? Y N

Are you currently using any other medications? If yes, what? (i.e. Tamoxifen) _____

Are you currently using a progesterone cream (applied to: Breasts only Rotating body areas) Y N

Do you feel that you are overweight? If yes, how many pounds overweight? _____

Have you had your ovaries removed? If yes, at what age? _____

Are you experiencing any of the following with your breasts: None

A Lump (date found _____; by Self Doctor. Is it Hard Soft Mobile Tender)

Pain: Dull Sharp Burning Stinging Tenderness The pain or tenderness changes with my cycle

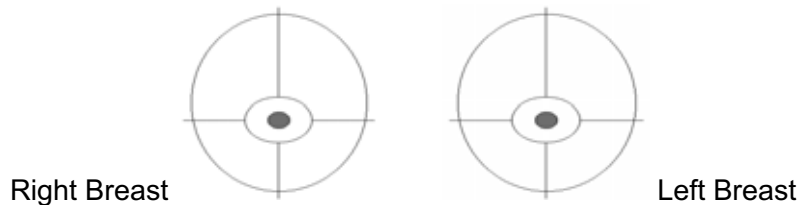
Thickening Skin changes (Color Texture Over the lump)

R L Nipple discharge (Bloody Milky Clear Through 1 duct Through multiple ducts)

R L Nipple retraction R L Nipple Changes (Color Texture)

Other _____

Place an [O] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [X] in the area of pain, tenderness, thickening, or skin changes.



Do not write below this line Risk: H M L Initial Exam Re-Exam Tech: _____

T = _____ F R L Nipple retraction R L Areola traction toward SLQ SMQ ILQ IMQ

R L Skin surface bulge or dimple SLQ SMQ ILQ IMQ R L Skin changes SLQ SMQ ILQ IMQ

R L Nipple Changes (Color Texture) R L Nipple discharge (Bloody Milky Clear – S M)