

Patient Name: \_\_\_\_\_ What breast concerns are you being seen for today? Describe: \_\_\_\_\_

**FAMILY BREAST HISTORY**

A. Is there a history of breast cancer in your blood related family? (If yes, complete section below) Yes No

|              | Yes   | One Breast | Both Breasts | Age at Diagnosis? | Treatment Received? | Circle One     |
|--------------|-------|------------|--------------|-------------------|---------------------|----------------|
| Grandmother: | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Mother:      | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Sister(s):   | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Daughter(s): | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Aunt(s):     | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Father:      | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Brother(s):  | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Son(s):      | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |
| Grandfather: | _____ | _____      | _____        | _____             | _____               | Alive/Deceased |

**PAST BREAST HISTORY**

A. Do you have any history of non-cancerous breast problems? (i.e, fibrocystic changes, mastitis) Yes No  
If yes, describe \_\_\_\_\_

B. Have you had any procedures/operations or needle biopsies on your breast(s)? (If yes, complete below) Yes No

| Procedure Date | Breast | Type of Operation | Hospital City/State | Surgeon |
|----------------|--------|-------------------|---------------------|---------|
| _____          | R L    | _____             | _____               | _____   |
| _____          | R L    | _____             | _____               | _____   |
| _____          | R L    | _____             | _____               | _____   |

C. Have you ever been diagnosed with breast cancer? (If yes, check ALL treatments listed below that apply) Yes No

|  |   |
|--|---|
| _____ Mastectomy (Surgical removal of breast)                        | _____ Radiation (treatment to breast)                                 |
| _____ Lumpectomy or Wide Excision (Removal of lump from breast only) | _____ Radiation (treatment to chest wall [scar] after breast removal) |
| _____ Chemotherapy   | _____ Hormone Therapy (i.e., Tamoxifen)                               |
|  | _____ Other _____   |

D. Have you ever received radiation (cobalt) treatments (to face, tonsils, skin, thymus for cancer)? Yes No  
If yes, How much? \_\_\_\_\_ How long?: \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

- |   |   |
|---|---|
| A. Age you began menstruating? _____  | E. Number of pregnancies? _____   |
| B. Are you still menstruating? <span style="float: right;">Yes No</span>                        | Number of completed deliveries? _____   |
| Did you stop naturally? <span style="float: right;">Yes No</span>                               | Age at first delivery? _____  |
| Due to surgery? <span style="float: right;">Yes No</span>                                       | F. Have you ever taken estrogens or hormonal pills? <span style="float: right;">Yes No</span> |
| C. Have you had surgery to remove your uterus (womb)? <span style="float: right;">Yes No</span> | If yes, how long? _____ Name? _____   |
| D. Any surgery to remove your ovaries? <span style="float: right;">Yes No</span>                | G. Have you ever taken birth control pills? <span style="float: right;">Yes No</span>         |
|   | If yes, how long? _____ Name? _____   |

**CONCERNS ABOUT BREAST CANCER**

Please tell us about anything not covered above that could help us with your care.

Patient Signature: \_\_\_\_\_ Dr./Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_