The Breast Health Center

NAME: _____

To help us better understand your needs, please answer the following questions.

What brings you to the Breast Health Center today?

- ☐ Abnormal mammogram
- ☐ Breast pain or discomfort
- ☐ Breast lump
- ☐ Consultation regarding breast tumor
- ☐ Treatment of breast cancer
- ☐ Second opinion
- ☐ High-risk for cancer in family
- ☐ Other_____

How did you hear about the Breast Health Center? _____

Where should we send a visit report to your physicians? Names:_____

_____

Breast Health History

Have you ever had a mammogram? ☐ No ☐ Yes – Facility & Date: _____

When was the previous mammogram before your last? _____

What is your bra size? _____

Have you ever had a breast biopsy? ☐ No ☐ Yes If yes, what were the results? _____

Were atypical cells noted? ☐ No ☐ Yes

Reproductive History

Age of first menstrual period: _____ Date of last menstrual period _____

Menopause? ☐ No ☐ Yes Age_____

Have you had a hysterectomy (date and reason)?_____ Ovaries removed?_____

How many times have you been pregnant?_____ How many children do you have?_____

How old were you at the birth of your first child?_____ Did you breastfeed? ☐ No ☐ Yes

Are you currently on a hormone replacement? ☐ No ☐ Yes – How long? _____

Have you been on hormone therapy in the past 5 years? ☐ No ☐ Yes – How long? _____

Are you taking, or have your ever taken, birth control pills? ☐ No ☐ Yes – How long? _____

Are you sexually active? ☐ No ☐ Yes

Are you having any troubles during intimacy? ☐ No ☐ Yes

Please list any current medications:_____

_____

_____

Allergies ☐ Yes ☐ No

If yes, please list with reaction: _____

_____

_____

Medical History

Height _____ Weight _____

☐ Osteopenia/ osteoporosis ☐ Seizures ☐ Scleroderma ☐ Heart problems

☐ High blood pressure ☐ Diabetes ☐ Kidney disease ☐ Heartburn

☐ Arthritis ☐ Cholesterol ☐ Thyroid condition ☐ COPD

☐ Asthma ☐ Blood clotting problems ☐ Anxiety/Depression

☐ Other Medical Issues _____

Have you had any type of cancer? _____

Have you ever had chemotherapy? _____

Have you ever had radiation? _____

Past surgical history (List operations and dates): _____

_____

Family History

Are you adopted? ☐ No ☐ Yes

Are you of Eastern European Jewish Ancestry? ☐ No ☐ Yes

Relationship (ex. mother, sister)	Cancer Type	Mother or Father's Side	Age at diagnosis Current age & status
Example: Aunt	**Breast**		45/60 cancer free

Number of daughters: _____ Number of sisters: _____

Number of maternal aunts: _____ Number of paternal aunts: _____

Social History

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Gender identity: _____ Preferred Pronoun: _____ Preferred Name: _____

Use of alcohol: ☐ Never Rarely ☐ Socially ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Quit When:_____ ☐ Current: Packs/day _____

Do you have a history of substance abuse? ☐ No ☐ Yes Type/Frequency

Occupational history: _____

Is anyone close to you threatening you or hurting you? ☐ No ☐ Yes

Is anyone forcing you to do something sexually that you do not want to do? ☐ No ☐ Yes

_____ _____ _____

Signature of Patient Signature of Physician Date