

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

What brings you to the Breast Health Center today?

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

When was your last bra fitting? _____ 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 taking, or have you ever used hormone replacement, and if so, what type? _____

How long have you been on them? _____

Are you taking, or have you 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 _____

- | | | | |
|-----------------------------------------------------|--------------------------------------|--------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Osteopenia/ osteoporosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Seizures | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Back or neck pain |
| <input type="checkbox"/> 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

I have no family history of cancer Are you adopted? No Yes

Are you of Eastern European Jewish Ancestry? No Yes

Relationship (ex. mother, sister)	Maternal (mother's side)	Paternal (father's side)	Cancer Type	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 Remarried Separated Divorced Widowed

Gender identity: _____

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: If you have worked, what type of work have you performed, and for what intervals?

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

Is anyone hitting, kicking, choking, or hurting you physically? No Yes

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

Excessive exposure at home or work to: Fumes Dust Solvents Air-borne particles Noise

Signature of Patient

Signature of Physician

Date