

Breast History Form

Name _____ D.O.B. _____

Physician referring you to clinic today: _____

Primary Care Physician: _____

Age: _____

Race: _____

Are you of Ashkenazi Jewish decent? Yes No

Reason for visit:

Have you experienced any breast pain? Yes No

Location of breast pain: Left Right Both

How often do you have breast pain? _____

Can you describe the pain? _____

Do you consume caffeine? Yes No

How frequently do you consume caffeine? _____

Have you ever had any breast trauma? Yes No

Have you ever had a breast infection or abscess? Yes No

Have you experienced any nipple discharge? Yes No

If yes, can you describe the color of the discharge?

Clear Green Milky Brown Bloody

Other: _____

Location of the discharge: Left Right Both

Name: _____

D.O.B. _____

Does the discharge occur only when the breast is squeezed? Yes No

Have you found a mass or lump in your breast? Yes No

Single or Multiple?

Location of mass/lump: Right Left Both

How long have you noticed the mass? _____

When and where was your last mammogram performed?

Have you had other recent breast imaging?

Ultrasound? Yes No Where and When? _____

MRI? Yes No Where and When? _____

Have you had any previous abnormal breast imaging? Yes No

Please explain:

—

Have you had any previous breast surgeries? Yes No

Have you had a breast biopsy? Yes No

Which breast? Right Left Both

When? _____

Was the biopsy benign or cancer? _____

Have you had any other type of surgery of your breast?

Have you ever had breast cancer? Yes No

Which breast? Right Left Both

Name: _____

D.O.B. _____

Do you know what type of cancer? _____

If you have had breast cancer, did you have chemotherapy? Yes No

Did you have radiation therapy? Yes No

Did you take hormone therapy for your cancer (for example: tamoxifen or arimidex)?

Yes No

If yes, how long have you taken the hormone therapy? _____

Do you have a family history of breast cancer? Yes No

If yes, please list the relationship and age at diagnosis:

_____ Age at Diagnosis _____

_____ Age at Diagnosis _____

_____ Age at Diagnosis _____

Has anyone in your family had any of these cancers?

Ovarian _____ Age at Diagnosis _____

Colon _____ Age at Diagnosis _____

Pancreatic _____ Age at Diagnosis _____

Melanoma _____ Age at Diagnosis _____

Thyroid _____ Age at Diagnosis _____

Prostate _____ Age at Diagnosis _____

Sarcoma _____ Age at Diagnosis _____

Do you have a family member with a history of any other type of cancer?

_____ Age at Diagnosis _____

Have you or any of your family members had genetic testing for the breast cancer gene?

Yes No

Name: _____

D.O.B. _____

If yes, what family member was tested and did they share the result of the test with you?

Age of first menstrual cycle: _____

Are you still having a menstrual cycle? Yes No

If no, age of menopause: _____

Have you had a hysterectomy (uterus removed)? Yes No

If yes, when? _____

If yes, do you have your ovaries? Yes No

Have you ever used or are you currently using hormone replacement therapy?

Yes No

If yes, how long was the use? _____

Have you used or are you currently using oral contraceptive pills? Yes No

If yes, for how long? _____

Age when you had your first birth: _____

Number of pregnancies: _____

Number of children: _____