

Breast Health History Form

Patient Name: _____

Today's Date: _____

1. Reason for today's visit : _____

2. Have you ever experienced any of the following...

An unresolved breast lump

Breast pain

Nipple discharge

A breast abnormality found on an exam

Significant breast trauma

Explain _____

3. Do you perform monthly self breast exams? Yes No

4. Date of last clinical breast exam: _____

5. Have you ever had a breast biopsy? Yes No

a. If yes, please specify when and whether it was a surgical biopsy or needle biopsy and diagnosis if known.

6. Beginning Date of last period: _____

7. Age of first period: _____

8. How many times have you been pregnant? : _____

9. How many living children do you have? : _____

10. Are you currently nursing or have you ever nursed? Yes No

11. Have you ever taken oral contraceptives? Yes No

a. If yes, please list starting and ending dates: _____

12. Do you or have you ever used hormone replacement therapy? Yes No

a. If yes, dates of use: _____

13. Do you have any family history of breast cancer, colon cancer or ovarian cancer? Yes No

a. If yes, please specify the type of cancer and family member (ex: Maternal Aunt-ovarian):
