Breast Health History Form

Patient Name: _____ Today's Date: _____

Reason for today's visit: _____

1. Have you ever experienced any of the following?

- ☐ An unresolved breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast abnormality found on an exam
- ☐ Significant breast trauma

Explain_____

- ☐ Change in breast skin (dimpling, puckering, redness, etc.)

2. Date of last clinical breast exam/ physical: _____

3. Have you had previous breast imaging (mammogram, ultrasound, MRI, etc.)? ☐ Yes ☐ No

If yes, please specify the date and type of imaging completed.

_____

4. Do you perform monthly self-breast exams? ☐ Yes ☐ No

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

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

_____

Please answer the following regarding hormone therapy and family history:

6. Do you or have you ever used hormone replacement therapy or steroids? ☐ Yes ☐ No

If yes, dates of use: _____

7. Do you have any family history of BREAST, COLON, OVARIAN, or PROSTATE CANCER? ☐ Yes ☐ No

If yes, please specify the type of cancer, family member and age diagnosed (ex: ovarian, maternal aunt, age 55):

_____

_____

Please answer below if applicable:

1. Beginning date of last period: _____

2. Age of first period: _____

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

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

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

6. Have you ever taken oral contraceptives? ☐ Yes ☐ No

If yes, please list starting and ending dates: _____