



Patient Identification Label

### BREAST HEALTH HISTORY FORM

Date of last physical breast exam by a doctor \_\_\_\_\_  Normal  Lump found —  Right  Left Breast

**NEW CHANGES OR CONCERNS**

None

R  L **Breast Lump:** (date found) \_\_\_\_\_

R  L **Breast Pain:**  Dull  Sharp  Burning  Stinging  Tenderness  Changes with my cycle

R  L **Thickening:**  Skin changes ( Color  Texture  Over the lump)

R  L **Nipple Discharge:**  Bloody  Milky  Clear  Other \_\_\_\_\_

R  L **Nipple Changes:**  Color  Texture

Other: \_\_\_\_\_

Do you have any diagnosed breast conditions?  None  Fibrocystic  Cystic  Other \_\_\_\_\_

**Date of last Mammogram:** \_\_\_\_\_

Was it:  Normal  Abnormal  Suspicious  Something is being watched

**Date of last breast ultrasound:** \_\_\_\_\_

Was it:  Normal  Abnormal  Suspicious  Something is being watched

**Date of last breast MRI:** \_\_\_\_\_

Was it:  Normal  Abnormal  Suspicious  Something is being watched

**PREVIOUS BREAST BIOPSIES/SURGERIES**

Any breast biopsies? When? \_\_\_\_\_  Right  Left Breast

What was found on the biopsy?  Cancer  Other \_\_\_\_\_  Right  Left Breast

Any breast surgeries? When and what was done? \_\_\_\_\_  Right  Left Breast

Any breast reconstruction? When and what was done? \_\_\_\_\_  Right  Left Breast

If you have had any radiation treatment, when was it last performed? \_\_\_\_\_  Right  Left Breast

**GYNECOLOGICAL HISTORY**

Are you currently nursing?  Yes  No

Are you currently pregnant?  Yes  No

Current cycle day (number of days since first day of period) \_\_\_\_\_

If you have passed menopause, at what age did it begin? \_\_\_\_\_

If you are taking hormone replacement, at what age did you start? \_\_\_\_\_ How many years taken? \_\_\_\_\_

Are you currently taking hormones?  Yes  No (check if only by prescription):  Estrogen  Progesterone

Have you had your ovaries removed? If yes, at what age? \_\_\_\_\_

**Do you have any family history of breast or ovarian cancer?**

Self  Mother  Sister  Daughter  None *Maternal* —  Grandmother  Aunt

*Paternal* —  Grandmother  Aunt

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

