Name: ____________ City: ____________ State: ______ Zip: ________ DOB: __________

Employer: ____________________ Best Time of Day to Contact You and number: ____________________

Spouse/Significant Other Name: ____________________ Employer: ____________________

Outside imaging history dates and locations: Mammogram: ______________ Breast ultrasound ____________

Breast MRI ______________

Are you Pregnant? ☐ Yes ☐ No Have you had any vaccines in the past 6 weeks? ☐ Y ☐ N Which arm? ☐ L ☐ R

List all physicians you would like to receive your report: ____________________

New Problems (Mark all that apply today)				*For office use only (do not write in this area)*
Lump or Mass	☐ Y ☐ N	☐ R ☐ L	How Long?	☐ general lumpiness ☐ focal lump / constant ☐ Y ☐ N
Thickening	☐ Y ☐ N	☐ R ☐ L	How Long?	
Focal Pain Tenderness	☐ Y ☐ N	☐ R ☐ L	How Long?	☐ constant pain/tenderness ☐ pain/tenderness comes and goes with cycle
New Nipple Retraction	☐ Y ☐ N	☐ R ☐ L	How Long?	
Nipple Discharge	☐ Y ☐ N	☐ R ☐ L	How Long?	Color? ____________ Spontaneous? ☐ Y ☐ N

Do you have a pacemaker, port-a-cath, or defibrillator?	☐ Y ☐ N		
Have you ever had a needle biopsy on your breast?	☐ Y ☐ N	☐ R ☐ L	Year:
Have you had surgery showing breast cancer?	☐ Y ☐ N	☐ R ☐ L	Year:
Have you had breast surgery that was not cancer?	☐ Y ☐ N	☐ R ☐ L	Year:
Have You had ☐ Breast Implants, ☐ Reduction or ☐ Breast Lift?	☐ Y ☐ N	☐ R ☐ L	Year:
Are You Post Menopausal or Have You Had your Ovaries Removed?	☐ Y ☐ N		Year:
Are you taking hormones (HRT)?	☐ Y ☐ N		How Long?
Have you been diagnosed with Rheumatoid Arthritis or other Collagen Vascular Disease?	☐ Y ☐ N		

Risk

Have You or a Family Member Ever Had Genetic Testing?	☐ Y ☐ N	Who? Results:

Other than a chest x-ray or CT scan, did you have radiation therapy to your chest or neck as a Child? ☐ Y ☐ N

Other than a chest x-ray or CT scan, have you had radiation therapy to the chest for lymphoma? ☐ Y ☐ N

Have You Had Atypical Hyperplasia or LCIS?	☐ Y ☐ N	

WOMEN'S HEALTH CENTER

BREAST HISTORY SHEET

▼ Patient Label ▼

Family History	Breast Cancer	Ovarian Cancer	Other Types Cancer	Age Detected	Side of Family
Self					
Mother					
Father					
Sister(s)					
Brother(s)					
Children					
Grandmother					Mother or Father
Aunt(s)					Mother or Father
Cousin(s)					Mother or Father
Niece(s)					Mother or Father

For office use only (do not write in this area)

R L

RIGHT LEFT

Have You Ever Been Diagnosed With BREAST CANCER If no, skip to SIGNATURE line below.	☐ Y ☐ N	☐ R ☐ L	
Has Your Cancer Been Surgically Removed?	☐ Y ☐ N		
Have You Had a Mastectomy?	☐ Y ☐ N	☐ R ☐ L	
Have You Had Reconstruction?	☐ Y ☐ N	☐ R ☐ L	☐ Implant or ☐ Tissue Flap (Check One)
Have You Ever Taken Chemotherapy?	☐ Y ☐ N		
Are You Currently Taking Hormonal Therapy?	☐ Y ☐ N	☐ Tamoxifen ☐ Arimidex ☐ Evista ☐ Letrozole ☐ Aromasin ☐ Faslodex	
Have You Had Radiation Therapy on Your Breast?	☐ Y ☐ N	☐ Whole Breast or ☐ Partial Breast (Check One)	

I authorize the release of any medical information, including x-ray images, necessary to Women's health Center for continuum of my breast health care.

Signature: ______________________________ ***Date:*** ______________________________

WOMEN'S HEALTH CENTER

▼ Patient Label ▼

BREAST HISTORY SHEET